Supreme Court, U.S.
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IN THE

# Supreme Court of the United States

PHYSICIANS INSURANCE COMPANY OF WISCONSIN; PAUL K.H. FIGGE, JR., M.D.; WISCONSIN PATIENTS COMPENSATION FUND,

*Petitioners*,

*v.*

KIMBERLY SCHREIBER, a minor by her guardian ad litem, JOHN KRUEGER; GERALD SCHREIBER and JANICE SCHREIBER,

*Respondents.*

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF WISCONSIN

## PETITION FOR A WRIT OF CERTIORARI

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## QUESTION PRESENTED

Does the Wisconsin Supreme Court decision in this proceeding violate Dr. Figge's right of self-determination, which is a constitutionally protected liberty interest under the Fourteenth Amendment to the United States Constitution, by forcing him to perform a procedure that he did not believe was medically appropriate?

## LIST OF PARTIES

Petitioner Wisconsin Patients Compensation Fund is a defendant below. Physicians Insurance Company of Wisconsin and Paul K.H. Figge, Jr., M.D., join in the petition and are defendants below. The State of Wisconsin and Employers Health Insurance Company are defendants below, but were not party to the appeal in the Wisconsin appellate courts.

Respondents Kimberly Schreiber and her parents, Janice and Gerald Schreiber, are the plaintiffs below.

## STATEMENT PURSUANT TO RULE 29.6

The petition accurately lists the parties to the proceeding.

Petitioners have no parent corporations and no publicly held company owns 10% or more of their stock.

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Petitioner the Wisconsin Patients Compensation Fund,[1] respectfully requests that a Writ of Certiorari be issued to review the opinion of the Wisconsin Supreme Court entered in this proceeding.

## OPINIONS BELOW

The opinion of the Wisconsin Supreme Court is reported at *Schreiber v. Physicians Insurance Co.*, 223 Wis. 2d 417, 588 N.W.2d 26 (1999) and reprinted in the Appendix hereto at App. A, page 1a. The order of the Wisconsin Supreme Court denying the motion for rehearing is not published. It is reprinted in the Appendix hereto at App. E, page 71a.

The opinion of the Wisconsin Court of Appeals is reported at *Schreiber v. Physicians Insurance Co.*, 217 Wis. 2d 94, 579 N.W.2d 730 (Ct. App. 1998) and is reprinted in the Appendix hereto at App. B, page 22a. The circuit court decision and order for judgment are not published. However, they are reprinted in the Appendix hereto at App. C and D.

## STATEMENT OF JURISDICTION

On January 26, 1999, the Wisconsin Supreme Court issued its opinion in this proceeding. On April 7, 1999, the supreme court denied a timely petition for rehearing.

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1. The Wisconsin Patients Compensation Fund is a statutorily created entity that is required to pay that portion of any medical malpractice claim against a participating health care provider, which exceeds the statutorily mandated primary liability insurance policy. *See* sec. 655.27(1), Wis. Stats. In this case, the Fund is required to pay all damages in excess of $300,000. *See* sec. 655.23(4), Wis. Stats. Damages have not been decided, but given the claimed injuries, they will far exceed the primary limits.

The jurisdiction of the Court is invoked pursuant to 28 U.S.C. § 1257.

## CONSTITUTIONAL RIGHT INVOLVED

The Wisconsin Supreme Court decision in this proceeding significantly interferes with Dr. Figge's right to self-determination. The right of self-determination is a liberty interest protected by the Fourteenth Amendment to the United States Constitution. Section 1 of the Fourteenth Amendment to the United States Constitution provides in relevant part: "No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law. . . ."

The supreme court decision holds that Dr. Figge, and all Wisconsin physicians in the future, have a duty to perform medical procedures, and provide medical treatments, on demand. Under the guise of informed consent law, Wisconsin now makes it mandatory for a doctor to physically provide any viable medical treatment, even when the doctor believes that the treatment is not appropriate under the circumstances or is opposed to performing the procedure for some other reason. The decisional law strips Wisconsin doctors of their right of self-determination. If a patient demands a procedure, the doctor must perform it or face liability under Wisconsin's informed consent law.

## STATEMENT OF THE CASE

### A. Introduction

To satisfy Wisconsin's informed consent law, before the supreme court's decision in this case, Wisconsin

physicians were required to inform their patients of the advantages and risks of a procedure, the viable options, and to perform only those procedures for which a patient had consented. *See* sec. 448.30, Wis. Stats; *Martin v. Richards*, 192 Wis. 2d 156, 531 N.W.2d 70 (1995); *Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 227 N.W.2d 647 (1975). Now, the informed consent law, under the decision in this case, requires Wisconsin doctors to provide treatment on demand, in addition to obtaining an informed consent.

Doctors no longer have the right of self-determination, when faced with a demand from a patient. A doctor may no longer decide what procedure is medically appropriate in his or her judgment. Instead, the doctor must perform the demanded procedure as long as it is a viable medical option, or face liability under the informed consent law.

While a patient has a right of bodily integrity, so has a physician. A patient has a right to refuse or receive medical treatment. A doctor should also have a right to decide whether or not to perform a procedure, or to provide a specific treatment. Unfortunately, the Wisconsin Supreme Court decision takes away that right.

**B. Factual Background**

The factual issue in this case was whether or not the defendant Dr. Figge obtained an informed consent from plaintiff Janice Schreiber to proceed with an attempted vaginal delivery, as opposed to a cesarean section. (At the time of trial, there was no medical malpractice claim. The Schreibers were not alleging that Dr. Figge misdiagnosed Mrs. Schreiber's condition, nor were they alleging that he had breached the standard of care by failing to perform the cesarean sooner).

On June 25, 1988, the plaintiff, Janice Schreiber, gave birth to her third child, Kimberly. *See* App. D, at 49a-50a. Before giving birth to Kimberly, Mrs. Schreiber had delivered two other children, both by cesarean section. *See Schreiber*, 217 Wis. 2d at 98; App. B at 23a. The first cesarean was performed on November 9, 1981, because of insufficient progress in labor after seventeen hours. *Id.*; App. D, at 48a. A second cesarean was performed to deliver Mrs. Schreiber's second child, on February 13, 1984, because at that time, it was the standard of care to perform an elective repeat cesarean (in accordance with the " 'once a cesarean always a cesarean' rule.") *Schreiber*, 223 Wis. 2d at 421; App. A, at page 3a. Dr. Figge served as Mrs. Schreiber's obstetrician during both pregnancies and performed both cesareans. *Id.* at 420; App. A at 2a.

Satisfied with Dr. Figge's care, Mrs. Schreiber returned to him when she became pregnant for the third time in 1987. In 1987 and 1988, the prevailing medical research and practice suggested that a vaginal birth after cesarean (VBAC) was no more dangerous than undergoing another cesarean birth. *Id.* at 421; App. A at 3a. In fact, the research showed that the VBAC presented less risk than the cesarean.[2] *Id.*

During Mrs. Schreiber's prenatal care, she and Dr. Figge discussed the possibility of a vaginal delivery as an alternative to a third cesarean. *Id.* (The medical records

2. Medical literature at that time suggested that physicians encourage their patients to have a vaginal birth after cesarean (VBAC), because vaginal deliveries had fewer risks than a cesarean; that 60 percent of women who attempted vaginal delivery were successful; and the risk of uterine ruptures (the fear previously prompting repeat caesareans) had shown that the right of uterine ruptures were successful.

reflect that the two discussed the topic on at least four separate occasions during Mrs. Schreiber's appointments.) After being given a choice between the cesarean and a vaginal delivery, Mrs. Schreiber chose the vaginal delivery. *Id.* Mrs. Schreiber testified that Dr. Figge offered her the option but did not attempt to influence her decision either way. The trial court concluded that Mrs. Schreiber had given her informed consent to the VBAC, before her labor began. *Schreiber*, 217 Wis. 2d at 101; App. B at 27a. This finding was not appealed. *See id.*; *See also Schreiber*, 223 Wis. 2d at 428; App. A at 11a.

Mrs. Schreiber began experiencing labor pains in the evening of June 24, 1988. App. D at 49a. She was admitted to the hospital at about 4 a.m. on June 25. *Id.* Dr. Figge first saw Mrs. Schreiber at the hospital, in the corridor, four hours later, at about 8:00 a.m. At that time, Mrs. Schreiber told Dr. Figge that she had changed her mind and that she wanted a cesarean. *Id.* Dr. Figge told Mrs. Schreiber that they should return to her room so that he could examine her. *Id.*

Because the progress in Mrs. Schreiber's dilation was limited, Dr. Figge performed an amniotomy, the breaking of the mother's amniotic fluid sac, to help the labor progress more efficiently. *Id.* Shortly thereafter, Mrs. Schreiber began experiencing severe upper epigastric pain. *Id.* She was given pain medication at 9:30 a.m., which provided limited relief. *Id.*

At 1:00 p.m., Dr. Figge returned to Mrs. Schreiber's room and examined her. *Id.* He also attempted to ascertain the source of Mrs. Schreiber's pain. Dr. Figge concluded that the baby was not in distress. The amniotic fluid was

clear, with no evidence of a bleed. Mrs. Schreiber's abdomen was soft, and her uterus was not tender. Mrs. Schreiber's pain was not in the area of her uterus. Given the symptoms, Dr. Figge did not believe that Mrs. Schreiber had a ruptured uterus.[3] Dr. Figge concluded that neither Mrs. Schreiber's uterus nor her placenta was the source of the pain. He advised Mrs. Schreiber of his conclusion. Mrs. Schreiber testified that she again asked for a cesarean. *Id.* at 49a. Dr. Figge told Mrs. Schreiber to give the vaginal delivery more time. *Id.*

Mrs. Schreiber again requested a cesarean and, according to Mrs. Schreiber, Dr. Figge responded something to the effect of "If I gave every woman a cesarean who was in labor, they would all want one." *Schreiber*, 223 Wis. 2d at 422; App. A at 5a. Mrs. Schreiber claims that she stopped talking due to Dr. Figge's comment, which she perceived as brusque and which also hurt her feelings.

At about 1:45 p.m., Dr. Figge returned to Mrs. Schreiber's room. *Schreiber*, 223 Wis. 2d at 423; App. A at 5a; App. D at 64a. He told her that her contractions were not strong enough. He also advised her that he would be administering Pitocin, a drug which stimulates effective labor, to augment the labor process. Dr. Figge told Mrs. Schreiber if the labor did not progress with the Pitocin, he would then perform a cesareans.

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3. If a patient has a uterine rupture, the uterus itself would be tender. Also, the leakage of fluid or blood into the abdominal cavity would result in the abdomen feeling hard. Mrs. Schreiber did not show these symptoms. If the placenta was separating from the uterus, the early symptom would be pain near the uterus, which Mrs. Schreiber did not exhibit. Some women in labor complain of pain not associated with contractions, and the cause is not always discovered. App. D at 66a.

Dr. Figge testified that he thought Mrs. Schreiber had agreed with his plan and recommendation. Mrs. Schreiber did not refuse the treatment. Pitocin was started and administered at a low level at 1:48 p.m. The dose was increased every 20 minutes, and by 3:00 p.m., Mrs. Schreiber was receiving 8 milliunits of Pitocin. The maximum dose allowable was 20 milliunits.

Dr. Figge examined Mrs. Schreiber at 2:45. Her abdomen remained soft, and she did not have tenderness near her uterus. She did, however, continue to complain of epigastric pain.

At 3:00 p.m., Mrs. Schreiber received an epidural anesthetic. At 3:40 p.m., the fetal heart rate dropped. *See id.* at 423; App. A at 5a. This required an emergency cesarean shortly after 4 p.m. *Id.* Kimberly Schreiber was born a spastic quadriplegic. *Id.*

**C. Summary of Proceedings Below**

The Schreiber's initial claim against Dr. Figge alleged both medical malpractice and a violation of the informed consent statute. App. D at 50a. Before trial, however, the Schreibers dropped the malpractice claim. *Id.* Therefore, the issue was not whether or not Dr. Figge's conduct was appropriate, but rather whether or not Mrs. Schreiber had given her informed consent.

1. *Trial Court's Decision.*

The parties stipulated to a court trial on liability on the informed consent issue. (The parties also stipulated that had a cesarean been performed before 3:29 p.m., Kimberly's injuries would not have occurred). *Schreiber*, 223 Wis. 2d at 423; App. A at 5a.

The circuit court ruled in favor of Dr. Figge. The circuit court found that Mrs. Schreiber had given her informed consent to a VBAC, that nothing had occurred during the course of Mrs. Schreiber's labor that altered the labor to require a new consent, and that a reasonable person in the position of Mrs. Schreiber would have followed Dr. Figge's advice and continued with labor (which is exactly what Mrs. Schreiber had done). App. D at 60a and 69a-70a. The trial court's findings required the dismissal of the plaintiffs' claims.

The trial court, in its opinion, pointed out the complexities of the case:

> This has been an unusually difficult case, primarily because of the blurring of the lines between diagnosis or medical management on the one hand and informed consent on the other.

*Id.* at 52a. (The opinion of the Wisconsin Supreme Court ultimately blurred the lines between the two separate and distinct theories of liability).

The circuit court concluded that "once the procedure elected has been initiated, . . . a request for a change does not thereby require an informed consent discussion. At [that] point the election has been made and the procedure in progress." *Id.* at 62a. As Dr. Figge testified, "his duty was to manage her labor and to help her achieve her goal as long as it was safe." *Id.*

> [F]ollowing an informed consent to a specific treatment procedure, once the procedure has commenced, the duty of the doctor is to seek to

> achieve its goal, but if the situation changes to increase the risks presented to the patient and there are alternative, viable medical modes of treatment available, then a renewed [informed consent] discussion . . . needs to take place.

*Id.* at 63a. Since Mrs. Schreiber had been informed of the risks and advantages of the VBAC, and had consented to it, the informed consent law was satisfied. Nothing new or different had occurred during the labor that had not been discussed during the original informed consent discussion between Mrs. Schreiber and Dr. Figge. *See id.* at 66a. Mrs. Schreiber, before the procedure began (i.e. the vaginal delivery) had been advised of the risks, and complications. (The issue of a violation of the standard of care, for not performing the procedure requested by the plaintiff, or for misdiagnosing the condition, is a different issue. That involves the standard of care under the circumstances. It does not involved the doctrine of informed consent. *See id.* at 67a).

2. *Decision of the Wisconsin Court of Appeals.*

The Schreibers appealed the trial court's judgment, which had dismissed their informed consent claim. On appeal, as in the trial court, Dr. Figge, his insurer and the Fund [hereinafter collectively referred to as "Dr. Figge"] argued that requiring a physician to perform a surgery demanded by the patient interferes with the physician's right to self-determination. The physician should not be compelled against his or her will to perform a procedure, or provide medical treatment, that the doctor does not wish to perform or provide.

On February 17, 1998, the Wisconsin Court of Appeals issued its opinion, which reversed the trial court judgment. *See* App. B at 22a; *Schreiber*, 217 Wis. 2d 94, 579 N.W.2d 730 (Ct. App. 1998). In a two to one decision by the three member court, the majority of the court of appeals held that Dr. Figge had violated the informed consent law by not performing the cesarean when requested by Mrs. Schreiber.

One of the three court of appeals' judges, Judge Myse, wrote a dissenting opinion. *See Schreiber*, 217 Wis. 2d at 111 (Myse, J., dissenting); App. B at 38a. Judge Myse concluded that the majority decision violated Dr. Figge's right to self-determination. *See Id.* at 113; App. B at 41a. Judge Myse pointed out that Wisconsin's informed consent statute provides that:

> Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments. The physician's duty is to inform the patient. . . .

*Id.* at 111; App. B at 39a (quoting sec. 448.30, Wis. Stats.) *See also Martin v. Richards*, 192 Wis. 2d 156, 173-74, 531 N.W.2d 70 (1995); *Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 227 N.W.2d 647 (1975). Judge Myse also noted that "[t]he Wisconsin informed consent statute cannot be fairly read to compel either Figge or any other doctor to perform a treatment the doctor does not believe is medically indicated." *Id.* at 112; App. at 40a.

Judge Myse further noted that "[t]he plain language of the informed consent statute merely requires the doctor to provide the patient with information sufficient to allow the

patient to either consent or withhold consent to the doctor's proposed medical treatment." *Id.* "The plain language of the informed consent statute and [the common law] demonstrate that there was no intent to require a doctor to perform medical treatment on demand. Figge should not be held liable for failing to do so here." *Id.* at 113; App. B at 40a. Judge Myse reasoned that the court of appeals' decision compelled "a doctor to perform a treatment the doctor does not believe is medically indicated and does not want to do." *Id.* at 113; App. B at 41a.

The dissenting opinion also highlighted the problem with the rule adopted here:

> Figge's refusal to perform the cesarean was based on his belief that it was bad medical practice to perform a cesarean based on complaints of pain alone. If his medical judgment concerning the appropriateness of a cesarean was incorrect, Figge may be liable in a medical malpractice claim. But Figge's refusal to carry out a treatment that he believes is contraindicated does not implicate the informed consent statute.

*Id.* at 113-14 (App. B at 41a).

After a complete informed consent conference during her prenatal care, Mrs. Schreiber chose a VBAC as the course of treatment for her delivery, instead of a repeat cesarean. Given Mrs. Schreiber's decision, Dr. Figge proceeded as he would with any other patient who had chosen that option. Dr. Figge believed, in his medical judgment, that it was inappropriate to perform a cesarean based upon pain alone. Dr. Figge could be held liable for

medical malpractice if his medical judgment concerning the appropriateness of a cesarean was incorrect. *Id.*; App. B at 41a. However, Dr. Figge's decision not to perform a procedure that he believes is contraindicated "does not implicate the informed consent statute." *Id.* at 114; App. B at 41a. Judge Myse correctly pointed out that the informed consent law obligates a physician to explain all viable, medical modes of treatment. *Id.* "This recognizes that there may be a number of feasible approaches to a specific medical problem. But simply because a medical procedure is feasible does not make such a procedure preferable or even desirable." *Id.*; App. B at 41a-42a. "The doctor should retain the right to refuse to follow a course of treatment that contravenes the doctor's opinion as to proper medical practice and procedure." *Id.*; App. B at 42a. Any other result places the doctor in the position of violating the informed consent law, by not performing the procedure demanded, or committing medical malpractice, by proceeding with the demanded procedure.

3. *Decision of the Wisconsin Supreme Court.*

Dr. Figge appealed the court of appeals' decision to the Wisconsin Supreme Court. There, as in the court of appeals, Dr. Figge argued that a rule requiring him to perform a procedure, or provide treatment, that he did not believe should be performed, violated his self-determination rights. The supreme court, however, issued a decision that did not address the violation of Dr. Figge's right to self-determination.

In its decision, the Wisconsin Supreme Court held that Dr. Figge had violated the informed consent law. Contrary to the circuit court's findings, the supreme court found that

Mrs. Schreiber had withdrawn her consent to the VBAC, while in labor. *See Schreiber*, 223 Wis. 2d at 430; App. A at 13a. The supreme court further found that the withdrawal of consent both removed Dr. Figge's authority to continue with the VBAC and "obligated him to conduct another informed consent discussion." *Id.* "The function of withdrawal, in effect, places [Mrs. Schreiber] and [Dr.] Figge in their original position-a physician, a patient and a series of options for treatment. It creates a blank slate on which the parties must again diagram their plan." *Id.* at 431; App. A at 14a. The supreme court did not address the fact that Dr. Figge, in his own medical judgment, believed that a cesarean was not an appropriate course for pain alone. (The fact that the cesarean may or may have remained a "viable" option during the course of labor was not relevant to that issue).

The supreme court included a "cautionary note" in its opinion.

> [T]his opinion should not be interpreted as creating a patient's right to demand any treatment she desires. Further, this opinion should not be interpreted as requiring physicians to perform procedures they do not consider medically viable, procedures for which they lack the appropriate expertise, or procedures to which they are morally opposed.

Unfortunately, the concerns addressed in the "cautionary" comment are precisely the result reached by the court.

The supreme court's decision blurs the line between a claim of informed consent and a claim of medical

negligence. In so doing, it took away Wisconsin doctors' right of self-determination. Now, when faced with a demand for a specific treatment, the doctor must perform it.

The Fund filed a timely motion for rehearing with the supreme court. It was denied.

## REASONS FOR GRANTING THE WRIT

The Wisconsin Supreme Court's decision is bad public policy. Not only does it significantly interfere with Dr. Figge's right of self-determination, it has dire consequences for all physicians in Wisconsin. Wisconsin doctors, under the decisional rule, are compelled to physically perform a procedure, or to provide medical treatment, simply because the patient demands it. The supreme court's decision significantly interferes with a doctor's constitutionally protected right of self-determination.

### I. DOCTORS, AS WELL AS PATIENTS, HAVE A RIGHT TO SELF-DETERMINATION AS A CONSTITUTIONALLY PROTECTED LIBERTY INTEREST.

This lawsuit began as a discussion of patients' rights. Ironically, it resulted in stripping doctors of their rights. Dr. Figge's right to self determination was taken away.

The right of self-determination mandates that no court, government or entity should substitute its judgment for that of another person's judgment with regard to that person's own bodily integrity. The right to self determination is rooted in the liberty right of the Fourteenth Amendment to the United States Constitution. *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261, 269 (1990). The Fourteenth

Amendment provides that no State shall "deprive any person of life, liberty, or property, without due process of law." The right to self-determination is an outgrowth of the historic liberty interest in personal security and bodily integrity. *See Ingraham v. Wright*, 430 U.S. 651, 673 (1977); *Union Pac. R. Co. v. Botsford*, 141 U.S. 250, 252 (1891). It is a constitutionally protected autonomy right. Each man or woman is considered to be master of his or her own body.

### A. The Right to Self-Determination Protects the Integrity of One's Own Body.

As early as 1884, the Supreme Court recognized that the liberty right of the Fourteenth Amendment protected the integrity of one's own body. *Hurtado v. People of California*, 110 U.S. 516, 536 (1884). In 1891, the Supreme Court explicitly stated that " '[n]o right is more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.' " *Cruzan*, 497 U.S. at 269 (quoting *Union Pac.*, 141 U.S. 250, 251 (1891)). "[O]ur notions of liberty are inextricably entwined with our idea of physical freedom and self-determination." *Id.* at 287 (O'Connor, J., concurring). " 'Liberty,' if it means anything, must entail freedom from governmental domination in making the most intimate and personal of decisions." *Rust v. Sullivan*, 500 U.S. 173, 216 (1991) (quoting *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 444 (1983); *Maher v. Roe*, 432 U.S. 464, 473 (1977)).

The Supreme Court has recognized that a person has the right to consent to and refuse medical treatment, which

is a liberty interest right of self-determination. *See Cruzan v. Missouri Department of Health*, 497 U.S. 261, 278 (1990); *Washington v. Harper*, 494 U.S. 210, 221-222 (1990). *See also Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972) ("[t]he root premise is the concept, fundamental in American jurisprudence, that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . .' " (quotation omitted)). In *Roe v. Wade*, 410 U.S. 113 (1973), the Supreme Court affirmed the principle that a person has the right, grounded in the Fourteenth Amendment's due process clause, to control fundamental decisions involving his or her own body. The right to personal autonomy was reaffirmed in *Akron*, 462 U.S. 416, 419-20 (1983). *See also Winston v. Lee*, 470 U.S. 753, 762 (1985); *Schmerber v. California*, 384 U.S. 757, 772 (1966) ("[t]he integrity of an individual's person is a cherished value of our society").

**B. The Right of Self-Determination Protects a Wisconsin Doctor, as Well as Patients, From Being Compelled to Do Something Against His or Her Will.**

A doctor, just like his or her patient, has a right to self-determination. The doctor has a constitutionally protected liberty interest in his or her own bodily integrity. The Wisconsin Supreme Court's decision in *Schreiber* violates that right of self-determination. The decision compels doctors to physically perform, or provide, whatever procedure or treatment is demanded by the patient. A doctor may decide not to perform a specific procedure for many reasons. It may be medically inadvisable. The procedure may subject the doctor to malpractice. The procedure may be against the doctor's religious beliefs. The supreme court's decision, however, takes away Wisconsin doctors' right to decide whether or not to perform a procedure.

## II. INFORMED CONSENT LAW SHOULD NOT COMPEL A DOCTOR TO PERFORM A PROCEDURE THAT IS NOT MEDICALLY APPROPRIATE.

Here, Dr. Figge believed that the medically appropriate treatment, given the treatment selected by Mrs. Schreiber (i.e. the VBAC), was to continue with the VBAC. There was no indication for a cesarean, other than the patient's pain. At trial, the expert witnesses agreed that a certain percentage of patients request cesareans to end the pain of labor. Dr. Cruikshank, a board certified obstetrician and gynecologist, with a subspecialty of high risk obstetrics, who was called by the defense, testified that such requests are "very frequent." Dr. Meier, also board certified in obstetrics and gynecology, as well as maternal-fetal medicine and high risk obstetrics, who was also called by the defense, testified that patients ask for cesareans "with great regularity." (R. 100 at 45, 173-4). Dr. Cruikshank testified that some women in labor desire sterilization, but that once the labor is completed, they would regret such a choice. Dr. Klavan, plaintiffs' expert, testified that he would never perform a cesarean unless it was medically indicated, despite the patient's wishes. (R. 91 at 100). Dr. Klavan also agreed that he would disregard a mid-labor request for sterilization for the same reason. (R. 91 at 110-11). Plaintiffs' other expert, Dr. Giles, was the only expert who testified that he would perform a cesarean based solely on the patient's request, but even he admitted that he would recommend continuation of labor if a cesarean was not medically indicated. (R.98 at 168-169).

**A. Dr. Figge Risked Committing Medical Malpractice By Proceeding With Mrs. Schreiber's Demands.**

Here, Dr. Figge fulfilled the informed consent law before Mrs. Schreiber went into labor. Mrs. Schreiber, knowing all of the risks, benefits and viable options (including a cesarean) chose to proceed with a vaginal delivery. When Mrs. Schreiber went into labor, Dr. Figge proceeded with the course chosen by Mrs. Schreiber and he treated Mrs. Schreiber as he would any other patient who had chosen a vaginal delivery. During Mrs. Schreiber's labor, Dr. Figge made the clinical judgment that a cesarean was not appropriate for pain only. (The surgery was not indicated under the circumstances). Had Dr. Figge been forced to perform the demanded procedure, the cesarean, and something had occurred during the cesarean, Dr. Figge could have been found guilty of medical malpractice. There clearly were risks associated with the cesarean, which had been discussed with Mrs. Schreiber before her labor began. For example, if Mrs. Schreiber died during the cesarean, because of some anesthesia accident, Dr. Figge would have been criticized for proceeding with the cesarean simply because the patient had demanded it for pain relief, when there were no other symptoms requiring the procedure.

If Mrs. Schreiber had demanded sterilization during her labor, so that she would not have to endure the pain again, under the supreme court's decision, Dr. Figge would have been compelled to perform a tubal ligation or hysterectomy to satisfy the informed consent law. Sterilization was certainly always a viable medical option. However, after the delivery, Dr. Figge could have been subjected to malpractice for performing the procedure as a way of relieving pain in the future.

### B. Dr. Figge Will Not Be the Only Wisconsin Doctor Who Loses His Right to Self-Determination.

Dr. Figge will not be the only Wisconsin doctor affected by the Wisconsin Supreme Court's decision. Other doctors will be forced to perform surgeries that they do not agree with, thereby violating their rights to self-determination.

Many potential examples of when the supreme court decision will compel action, against a doctor's will, can be envisioned. For example, a man arrives at the emergency room with a severe cut on his finger. The emergency doctor advises the man that there are several viable options for treatment, including surgical repair and amputation. The doctor strongly recommends the surgical repair. The patient agrees to proceed as recommended. During the repair, however, the pain is so intense, that the patient demands amputation. The doctor does not believe that amputation is the medically appropriate course of treatment and knows that the man is only requesting amputation because of the pain. Under the supreme court's decision, the doctor would be forced to conduct a second informed consent discussion, in the middle of the surgical procedure, and then perform the amputation as demanded by the patient. (This course would likely subject the doctor to a malpractice claim for performing the amputation, when it was not medically indicated, although it was a viable medical option).

### C. The Supreme Court Decision Compels the Doctor to Perform Whatever Procedure is Demanded, as Long as It is a Viable Medical Option.

The supreme court decision fails to appreciate that there is a difference between a viable medical option and an option

that is indicated. A viable option may include modes of treatment generally considered by the medical profession to be within the scope of current, acceptable standards of care. *See* Wisconsin Administrative Code, sec. Med. 18.02(3). With respect to treatment options, a viable method within the standard of care encompasses every method of treatment which does not fall to the level of unreasonable negligent conduct. *Nowatske v. Osterloh*, 198 Wis. 2d 419, 438, 543 N.W.2d 265 (1996). An "indicated" medical option refers to "a particular remedy or treatment as suitable or necessary." Random House Unabridged Dictionary 972 (2d ed. 1993). Many alternative methods of treatment may be within the accepted standard of care, but not suitable, necessary or recommended for an individual patient.

Consider a patient with a coronary artery blockage. Treatment within the current standard of care would include bypass surgery, angioplasty (insertion of a balloon-type device in the blocked vessel) or thrombolytic (clot bursting) medications. Since all are alternative, viable modes of treatment within the standard of care [*see*, Med. 18.02(3)], a physician has a duty to explain these as alternatives. For one patient, all three therapies may be indicated, and the patient can make an informed election after considering the risks and benefits of each. However, for another patient, only surgery may be indicated. Should the patient have a right to demand thrombolytic therapy because it is within the standard of care, although not indicated?

A physician following the *Schreiber* rationale may believe he then has a legal obligation to acquiesce to the patient's request and administer thrombolytics. As a consequence of this therapy, the patient could experience intracranial bleeding and brain damage which is a known

risk of treatment. Had the physician's judgment been the controlling force and therapy limited to what was indicated, the patient would not have been subjected to this risk. Rhetorically speaking, if such a scenario unfolds, can the physician then use *Schreiber* as a defense to a subsequent malpractice action? This scenario could play out every single day at every emergency department in this state.

Another everyday example might involve the development of a breast lump. Biopsy, mammogram and observation are methods of approaching this frequent occurrence. A physician may feel that a mammogram is appropriate and, based on the result, observation. The patient, quite understandably, may request a breast biopsy for "peace of mind." A well-trained physician acting within the highest standards may come to the judgment that a biopsy is not indicated. Nevertheless, at the patient's request, a surgical biopsy, which is contraindicated, is then performed. A minor complication, such a wound infection, or a major complication, such as an anesthesia accident, may result. Again, by complying with *Schreiber*, a physician could become subject to liability in a standard medical malpractice action for performing a surgical biopsy that was contraindicated.

There are undoubtedly more everyday examples which could be entertained. The cautionary language of the supreme court's decision cannot preclude situations such as these from actually occurring.

In this case, Dr. Figge did not believe that a cesarean was indicated until shortly before the emergency cesarean was performed. Dr. Figge concluded that the procedure was indicated when the baby's heart rate decreased. If Dr. Figge

had been wrong in his medical judgment, he could be held accountable through a claim of medical negligence. Under the circumstances presented, and all of the symptoms demonstrated, was it within the standard of care for Dr. Figge to continue with the VBAC, and not perform a cesarean. This is not an informed consent issue.

**D. Withdrawal as the Physician Is Not A Possibility For Avoiding the Problem.**

In the majority of cases, Wisconsin doctors will not have the option of withdrawing as the patient's doctor, in order to preserve their right to self-determination and to avoid performing the demanded surgery. Dr. Figge, when faced with Mrs. Schreiber's request for a cesarean, could not have simply walked away. He was in the middle of the treatment that had been selected by Mrs. Schreiber.

A patient has the right to know about and even select medical procedures that are available but not recommended by his or her doctor. However, the patient's right does not require a given doctor to perform a specific treatment. "The doctor should retain the right to refuse to follow a course of treatment that contravenes the doctor's opinion as to proper medical practice and procedure." *Schreiber*, 217 Wis. 2d at 114 (Myse, J., dissenting); App. B at 42a. Wisconsin doctors should maintain their right to self-determination, which would include making the decision as to whether or not to perform a procedure demanded by a patient.

## CONCLUSION

For the above-stated reasons, the Petitioner respectfully requests that this Court grant its Petition for a Writ of Certiorari.

Respectfully submitted,

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# APPENDIX

## APPENDIX A — OPINION OF THE SUPREME COURT OF WISCONSIN DATED AND DECIDED JANUARY 26, 1999

Kimberly SCHREIBER, a minor by her Guardian ad Litem, John Krueger; Gerald Schreiber and Janice Schreiber, Plaintiffs-Appellants,

v.

PHYSICIANS INSURANCE COMPANY OF WISCONSIN; Paul K.H. Figge, Jr., M.D.; Wisconsin Patients Compensation Fund, Defendants-Respondents-Petitioners,

STATE of Wisconsin and Employers Health Insurance Company, Defendants.

Supreme Court

*No. 96-3676. Oral argument October 7, 1998. — Decided January 26, 1999.*

(Affirming 217 Wis. 2d 94, 579 N.W.2d 730 (Ct. App. 1998).)

(Also reported in 588 N.W.2d 26.)

* * *

¶ 1. ANN WALSH BRADLEY, J. The defendants, Physicians Insurance Company of Wisconsin (Physicians Insurance), Dr. Paul K.H. Figge, Jr., and Wisconsin Patients Compensation Fund, seek review of a published decision

of the court of appeals that reversed the circuit court's dismissal of a suit brought by the plaintiffs Kimberly Schreiber and her parents, Janice and Gerald Schreiber.[1] They allege that Figge violated Janice's right to informed consent by failing to again conduct an informed consent discussion after Janice withdrew her consent to a vaginal delivery while in labor.[2] Because we determine that during her labor Janice withdrew her consent to a vaginal delivery and that at the time of her withdrawal there existed medically viable options for treatment, we conclude that her withdrawal constitutes a substantial change in circumstances requiring a new informed consent discussion. Additionally, we determine that a subjective test should be applied to the question of whether Figge's failure to conduct another informed consent discussion was a cause of the Schreibers' injuries. Accordingly, we affirm the court of appeals.

¶ 2. The relevant facts are essentially undisputed. This action stems from Janice Schreiber's labor and delivery of Kimberly Schreiber at Saint Mary's Hospital in Rhinelander, Wisconsin. This was Janice's third pregnancy. Figge served as Janice's obstetrician in all three of her pregnancies and delivered all three of her children. Her first two children were delivered by way of cesarean sections.

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1. *Schreiber v. Physicians Ins. Co.*, 217 Wis. 2d 94, 579 N.W.2d 730 (Ct. App. 1998) (reversing judgment of Circuit Court for Oneida County, James W. Karch, Reserve Judge).

2. Informed consent is codified at Wis. Stat. § 448.30 (1995-96). Unless otherwise noted, all further references to the Wisconsin Statutes will be to the 1995-96 version.

*Appendix A*

Figge performed the first cesarean delivery in 1981 because after over 17 hours of labor Janice still had not progressed to a point where a vaginal delivery was possible. At the time of Janice's second delivery in 1984, the prevailing medical practice followed the "once a cesarean always a cesarean" rule. As a result, Janice had her second child by cesarean delivery.

¶ 3. By the time of her pregnancy with Kimberly in 1987, the prevailing medical research and practice suggested that having a vaginal birth after cesarean (VBAC) was no more dangerous than having another cesarean delivery. In some circumstances a VBAC presented less risk to the health of both the mother and child than did another cesarean delivery. In the course of Janice's prenatal care she and Figge discussed a VBAC delivery as an alternative to another cesarean delivery. Figge recommended attempting the VBAC and Janice agreed to that course of treatment. Janice testified at trial that she was under the impression that she would first attempt the VBAC but could change her mind during labor and instead have another cesarean delivery. Figge testified that he understood Janice's pre-labor choice of the VBAC to be decisive, meaning that once her labor began Kimberly would be delivered vaginally unless and until Janice's symptoms medically warranted a cesarean section.

¶ 4. As her delivery neared, Janice went into labor and was admitted into the hospital at approximately 4:00 a.m. Janice signed consent forms for both a VBAC and cesarean delivery as part of her hospital admission. Figge first visited Janice's hospital room at 8:00 a.m. to see how her labor

was progressing. At that 8:00 a.m. visit Janice told Figge that she had changed her mind and wanted to abandon her plan for a VBAC and instead have another cesarean delivery. Figge urged Janice to continue with the VBAC. At approximately 8:30 a.m., Figge concluded that Janice's labor was not progressing as he had hoped. He then manually broke Janice's amniotic fluid sac in an effort to speed up the labor. Janice thereafter began experiencing excruciating abdominal pains sharply different from her contractions and unlike anything she had experienced with her prior deliveries. Nurses attempted unsuccessfully to ease the pain with various medicines. The pain was so unbearable that at one point Janice sent her husband to locate their nurse so that the nurse would again relay to Figge Janice's desire for a cesarean delivery.

¶ 5. Figge next checked on Janice at approximately 1:00 p.m. Again Janice complained of the abdominal pain. Figge attempted to diagnose the source of the pain but could not determine conclusively that it was caused by either a uterine rupture or separation of the placenta from the wall of the uterus. Figge concluded that the abdominal pains did not pose a danger to either Janice or Kimberly. He based this diagnosis primarily on his experience of seeing other women in labor suffer from similar abdominal pains that disappeared after delivery.

¶ 6. Also at this 1:00 p.m. visit Janice again informed Figge that she wished to cease the VBAC and instead have another cesarean delivery. Figge again instructed Janice to remain patient because he wanted to give the VBAC more time. When Janice protested, again complained of the pain,

and again requested a cesarean delivery, Figge tersely responded to the effect that if he performed a cesarean delivery on every woman who wanted one that all deliveries would be by cesarean section.

¶ 7. Janice later testified at trial that she was upset and intimidated by Figge's comment. As a result, she did not again bring the issue of ceasing the VBAC to Figge's attention. Figge later testified that he sensed no barrier between Janice and himself from that conversation. He further testified that at the 1:00 p.m. visit he knew that Janice would have preferred to have a cesarean delivery but that he thought the better course of treatment was to continue with the VBAC. Figge also testified that he would have acquiesced if Janice had further persisted in her requests for a cesarean delivery.

¶ 8. Janice's labor still did not progress as Figge would have liked. At 2:00 p.m. Figge again visited Janice's room to check on her condition. Figge again counseled Janice against the cesarean delivery and continued to advocate for continuing with the VBAC. After Figge's earlier terse statement, Janice did not reiterate her desire for a cesarean section. Figge interpreted her silence as her concurrence in continuing with the VBAC.

¶ 9. At 3:40 p.m. Kimberly's heart rate dropped. Figge was summoned and performed an emergency cesarean section at just after 4:00 p.m. It was too late. Janice's uterus had ruptured depriving Kimberly of oxygen. Kimberly was born a spastic quadriplegic and she cannot move below her neck or speak. The parties have stipulated that had Kimberly

been delivered prior to 3:29 p.m. she would have been born a healthy child.

¶ 10. The Schreibers sued Figge and his insurer, alleging both that Figge was negligent in his misdiagnosis of Janice's abdominal pain and that he violated Janice's informed consent rights. At some point in the litigation the Schreibers dropped their medical malpractice claim and proceeded to trial solely on the informed consent cause of action.

¶ 11. After a trial to the court, the circuit court found that Janice made an informed consent to the VBAC prior to the beginning of her labor. The circuit court also found that by the 8:00 a.m. meeting, Janice would have opted to discontinue the VBAC and instead have another cesarean delivery if Figge had offered her the choice. Although she repeatedly communicated this preference to Figge, he did not comply with her request. He knew the cesarean delivery was a viable medical option but did not consider it to be medically indicated. The circuit court held that Figge's duty was to manage Janice's labor in a way that would safely achieve the goal of delivery by VBAC upon the onset of labor.

¶ 12. The circuit court further concluded that Figge was under no obligation to re-advise Janice of her medical options or seek new consent when her labor did not progress as planned. The court reasoned that a doctor would only need to re-obtain consent when there was a substantial medical change in circumstances so that the patient faced risks unconsidered when the original consent was given.

The court determined that the risks Janice faced when her labor did not progress were no different than the risks she was made aware of when she originally gave her consent. The circuit court concluded that there was no substantial change in circumstances and dismissed the Schreibers' case.

¶ 13. The Schreibers appealed and contended that Janice's statements to Figge that she no longer wanted to continue with the VBAC were a withdrawal of her consent which triggered Figge's duty to have a new informed consent discussion. A divided court of appeals reversed the circuit court and concluded that where two or more medically acceptable options for treatment are present, the "competent patient has the absolute right to select from among [those] treatment options after being informed of the relative risks and benefits of each approach." *Schreiber v. Physicians Ins. Co.*, 217 Wis. 2d 94, 103, 579 N.W.2d 730 (Ct. App. 1998). It grounded its holding both in the informed consent statute and the common law right of bodily integrity from which the statute is derived. *Id.* at 103-04. The court of appeals determined that in order for the doctrine of informed consent to be effective, it must require a physician to do more than outline the methods of treatment available to a patient. Informed consent must also bind the physician to follow the course of treatment chosen by the patient so long as that chosen treatment is medically viable. *Id.* at 105.

¶ 14. The court of appeals reasoned that both the VBAC and cesarean delivery were viable medical options from the beginning of labor. Janice at first chose the VBAC. Some time into her labor she changed her mind and chose a

cesarean delivery. Thus, the court of appeals concluded that Figge violated Janice's informed consent right by refusing to follow her clearly communicated choice of treatment during labor. *Id.* at 107. Figge and Physicians Insurance petitioned this court for review.

¶ 15. Before delving into our analysis we first sound a cautionary note. This opinion does not address controversial issues at each end of the medical spectrum. Namely, this opinion should not be interpreted as creating a patient's right to demand any treatment she desires. Further, this opinion should not be interpreted as requiring physicians to perform procedures they do not consider medically viable, procedures for which they lack the appropriate expertise, or procedures to which they are morally opposed. Rather, this case is decided on narrow and discrete issues: (1) Did Janice withdraw her consent; (2) if so, did that withdrawal together with the existence of viable medical options for treatment trigger Figge's duty under the informed consent statute to again discuss the benefits and risks of her medical options; and (3) if such a duty exists, should an objective or subjective test be applied to the question of whether Figge's failure to conduct another informed consent discussion caused the Schreibers' injuries?

¶ 16. The issues present a mixed question of fact and law. We defer to the circuit court's findings of fact unless they are unsupported by the record and are therefore clearly erroneous. *Clarmar Realty Co., Inc. v. City of Milwaukee Redevelopment Authority*, 129 Wis. 2d 81, 94, 383 N.W.2d 890 (1986); Wis. Stat. § 805.17(2). However, the application of those facts to the pertinent law is a question of law which

we review independently of the determinations rendered by the court of appeals and circuit court but benefiting from their analyses. *Miller v. Thomack*, 210 Wis. 2d 650, 658, 563 N.W.2d 891 (1997).

¶ 17. The doctrine of informed consent traces its origins to the common law notion that an adult has a "right to determine what shall be done with his own body. . . ." *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (N.Y. 1914), *overruled on other grounds*, *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957). Originally founded on the common law tort of assault and battery, *see Paulsen v. Gundersen*, 218 Wis. 578, 584, 260 N.W. 448 (1935), the limitations of that theoretical framework became apparent with the passage of time. *Trogun v. Fruchtman*, 58 Wis. 2d 569, 598-99, 207 N.W.2d 297 (1973). Namely, a doctor's performance of an unauthorized treatment did not intuitively coincide with the "intentional, antisocial nature of battery" nor did it adequately reflect the fact that patients "consent" on some level whenever they see a doctor. *Martin v. Richards*, 192 Wis. 2d 156, 171, 531 N.W.2d 70 (1995). As a result, negligence — the doctor's failure to exercise reasonable care to a patient — replaced intentional battery as the theoretical underpinning for the doctrine. *Id.*

¶ 18. Over twenty years ago this court gave shape to the doctrine as it currently exists in Wisconsin. *Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 227 N.W.2d 647 (1975). In light of the fundamental purpose driving the doctrine, we concluded that a physician's duty to reveal the risks and benefits of available treatment options extended to the information a reasonable patient would need

to know in order to make an informed decision. *Id.* at 12-13. We stressed that physicians were not required to disclose absolutely every fact or remote possibility that could theoretically accompany a procedure. Rather, the touchstone of the test was what the reasonable person in the position of the patient would want to know. *Id.* at 13.

¶ 19. Within a few years after we decided *Scaria*, the legislature codified *Scaria*'s test as Wis. Stat. § 448.30.[3]

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3. **448.30 Information on alternate modes of treatment.** Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments. The physician's duty to inform the patient under this section does not require disclosure of:

> (1) Information beyond what a reasonably well-qualified physician in a similar medical classification would know.
>
> (2) Detailed technical information that in all probability a patient would not understand.
>
> (3) Risks apparent or known to the patient.
>
> (4) Extremely remote possibilities that might falsely or detrimentally alarm the patient.
>
> (5) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.
>
> (6) Information in cases where the patient is incapable of consenting.

*Appendix A*

The statute requires physicians to disclose information to patients about the viable medical modes of treatment so that when the patient chooses a method of treatment, that choice is made knowing both the reasonable risks and benefits of her decision.

¶ 20. There is no question on appeal that prior to Janice's labor, Figge satisfied the requirements of the informed consent statute. That issue was contested at trial and was resolved in favor of Figge. The Schreibers do not challenge that finding on appeal. Were that the whole of the story, this case would not have come before this court. The Schreibers argue that after Janice's initial consent but before Kimberly's birth a substantial change of circumstances occurred that nullified the original consent and obligated Figge to again have an informed consent discussion with Janice. That substantial change of circumstances was Janice's withdrawal of her consent where another medically viable option existed.

¶ 21. There is little doubt that consent, once given, is not categorically immutable. *See Mack v. Mack*, 618 A.2d 744 (Md. 1993) ("a corollary to [informed consent] is the patient's right, in general, to refuse treatment and to withdraw consent to treatment once begun"). If we determine as a matter of fact that consent was withdrawn, we must also determine as a matter of law whether consent can be withdrawn at this particular stage of the procedure.

¶ 22. The circuit court concluded that Janice initially agreed to the VBAC and that once labor began she could not change her decision unless there was a substantial

change in medical circumstances. It is undisputed that during her labor Janice told Figge on three separate occasions that she wanted to cease the VBAC and have a cesarean delivery. Moreover, Janice sent her husband to tell the nurse to relay the message to Figge yet another time. Though she never said the magic words, "I revoke" we conclude that her repeated statements are clear indication of her withdrawal of consent. The circuit court thought likewise, concluding that if Figge had put the "choice to her squarely," she would have chosen the cesarean. Even Figge recognized that Janice no longer desired to continue with the VBAC. He testified that he would have done the cesarean section had Janice persisted.[4] We are unsure, after three unsuccessful personal attempts and a fourth unsuccessful attempt through the nurse, how much more Janice could have done to convince Figge.

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4. Figge's testimony on cross-examination was as follows:

> Q. [A]s a hypothetical matter, if after [Figge discussed the matter with Janice,] Mrs. Schreiber had refused your recommendation, your recommendation being [to continue the VBAC], if there would have been a refusal to accept what you were recommending to the patient, Doctor, and a demand made at that point for repeat cesarean, what would you have done?
>
> A. Well, like I said, I would still have tried to encourage her to proceed, but, you know, if I wasn't able to convince her so that she would be comfortable proceeding and persisted, I think I would have to — probably have to go along with that request, but I have never had that situation.

¶ 23. Regardless of whether she factually withdrew her consent, the circuit court concluded that once a procedure has been initiated the time for a decision and discussions relating to that decision has passed. We reject the notion that the onset of a procedure categorically forecloses a patient's withdrawal of consent. To be sure, at some point in virtually every medical procedure a patient reaches a point from which there is no return. However, that point need not be arbitrarily created at the commencement of treatment. Rather it varies with the nature and circumstances of the individual procedure and continues so long as there exist alternative viable modes of medical treatment.

¶ 24. In this case, a cesarean delivery at all times remained a viable medical alternative to the VBAC and ultimately that is how Figge delivered Kimberly. Unlike the circuit court, we determine that since alternative viable modes of medical treatment existed, Janice was still able to withdraw her consent to the VBAC.

¶ 25. Having determined that Janice had withdrawn her consent to the VBAC, we must now examine the effect, if any, of that withdrawal. The Schreibers contend that her withdrawal both removed Figge's authority to continue with the VBAC and obligated him to conduct another informed consent discussion. We agree.

¶ 26. In considering Figge's authority to continue with the VBAC, we note well-settled law provides that a physician, absent exigent circumstances, may not perform a procedure on a competent adult without consent. *See, e.g., Lojuk v. Quandt*, 706 F.2d 1456, 1460 (7th Cir. 1983)

(applying Illinois law); *see also In the Matter of Guardianship of L.W.*, 167 Wis. 2d 53, 68, 482 N.W.2d 60 (1992) ("The logical corollary of the doctrine of informed consent is the right not to consent — the right to refuse treatment."); *Paulsen*, 218 Wis. at 583-84. Figge would not assert that absent Janice's consent to the VBAC he would nonetheless be authorized to attempt the procedure. The function of withdrawal, in effect, places Janice and Figge in their original position — a physician, a patient, and a series of options for treatment. It creates a blank slate on which the parties must again diagram their plan.

¶ 27. Since Figge no longer had consent to continue with the VBAC we are persuaded that Janice's withdrawal obligated Figge under the statute to again have an informed consent discussion with her. The circuit court reasoned that the physician's duty to again conduct an informed consent discussion occurred only if the medical circumstances were so changed as to alter the risks a patient faced from the time he or she first consented. Though not cited by the circuit court, this is essentially the position taken by the Colorado Supreme Court in *Gorab v. Zook*, 943 P.2d 423, 430-31 (Colo. 1997).

¶ 28. In *Gorab*, the Colorado Supreme Court concluded that, under Colorado law, a physician has no general duty to continue to explain the treatment options and their corresponding risks once the physician obtains consent and begins the procedure. *Id.* at 430. However, the Colorado court noted that "where a new, previously undisclosed, and substantial risk arises, there may be an additional and independent duty to warn" the patient of that risk. *Id.* The

*Gorab* court, much like the circuit court in this case, concluded that because any risks the patient faced during the procedure were risks previously disclosed, the physician was not under a duty to conduct another informed consent discussion.

¶ 29. As a general principle, we find *Gorab*'s and the circuit court's rationale convincing. If a patient consents to a procedure knowing the risks, the physician has satisfied his or her duty under the informed consent statute. We conclude, however, the circuit court erred in its determination of what could constitute a substantial change of circumstances. The circuit court only considered medical changes of circumstances. We conclude that it needed to consider legal changes of circumstances as well. A withdrawal of consent during the course of treatment to the treatment agreed upon before treatment constitutes a substantial change in circumstances triggering a physician's duty under the informed consent statute to re-advise the patient of the available treatment options and their risks.

¶ 30. Either a substantial medical or substantial legal change of circumstances results in an alteration of the universe of options a patient has and alters the agreed upon course of navigation through that universe. Where the change is medical, the alteration is a new risk or benefit previously unforeseen. Where the change is legal, the alteration is a withdrawal of an option previously foreseen. Though these cases travel from different directions, they arrive at the same destination: a new informed consent discussion. This discussion, much like any other such discussion, would have entailed the risks and benefits at

that time of the medically viable modes of treatment and again presented her an opportunity to choose her treatment.

¶ 31. This conclusion does not alter the principles of informed consent. Rather it more fully articulates those principles by applying the doctrine in a factual context we have previously not faced. Our cases to date have only dealt with the initial adequacy of the informed consent discussion. *See, e.g., Johnson v. Kokemoor*, 199 Wis. 2d 615, 545 N.W.2d 495 (1996) (informed consent discussion before the procedure did not adequately inform the patient of morbidity rates and the physician's lack of experience in performing the procedure); *Martin*, 192 Wis. 2d at 167-69 (the informed consent discussion did not reveal the availability of a CT scanner and the unavailability of a neurosurgeon at the particular hospital); *Scaria*, 68 Wis. 2d at 3-9 (the informed consent discussion failed to inform patient that dye used for x-rays could cause paralysis or death); *Trogun*, 58 Wis. 2d at 592-604 (the informed consent discussion failed to explain potential side effects of drug for tuberculosis).

¶ 32. This case, however, asks us to determine the continuing vitality of an informed consent discussion. We decline to view the informed consent discussion as a solitary and blanketing event, a point on a timeline after which such discussions are no longer needed because they are "covered" by some articulable occurrence in the past. Rather, a substantial change in circumstances, be it medical or legal, requires a new informed consent discussion. *See, e.g., Paulsen*, 218 Wis. at 583-84 (consent for "simple" mastoid operation not sufficient for "radical" version of the same

operation). To conclude otherwise would allow a solitary informed consent discussion to immunize a physician for any and all subsequent treatment of that patient.

¶ 33. Consistent with Wis. Stat. § 448.30 Figge had a duty to conduct another informed consent discussion and should have again presented Janice her treatment options and given her the opportunity to choose. His failure to do so was a violation of that duty.

¶ 34. As with any negligence action, a party must show the breach of a duty that caused an injury. Having determined that Figge breached his duty under the informed consent statute, we now turn to whether the circuit court erred in applying an objective test to the question of whether Figge's failure to again conduct an informed consent discussion was a cause of the Schreibers' injuries. *See Martin*, 192 Wis. 2d at 182.

¶ 35. Since at least *Scaria*, this court has agreed with the majority of American jurisdictions in employing what is known as the "objective test." *Scaria*, 68 Wis. 2d at 12-15. The objective test focuses on what the attitudes and actions of the reasonable person in the position of the patient would have been rather than on what the attitudes and actions of the particular patient of the litigation actually were. It asks two questions. First, did the physician fail to give information that a reasonable patient would want to know? *Kokemoor*, 199 Wis. 2d at 632. Second, given the additional information, would the reasonable patient have acted differently than they did without the information? *Martin*, 192 Wis. 2d at 182.

¶ 36. We adopted this objective test because it is more amenable to the adverse nature of litigation. Litigation rarely occurs in the absence of injury. With this in mind, we have concluded that the objective test is more "workable and more fair" than asking the fact finder to determine the question of liability in large part on the credibility of a plaintiff whose testimony is tempered by the occasion of an undesirable event. *Scaria*, 68 Wis. 2d at 15; *Canterbury v. Spence*, 464 F.2d 772, 791 (D.C. Cir. 1972) ("[The subjective test] calls for a subjective determination solely on testimony of a patient-witness shadowed by the occurrence of the undisclosed risk.").

¶ 37. We reaffirm our commitment to the objective test when faced with a traditional informed consent case. The rationale for the objective test set forth in *Scaria* has worn well in the decades that have passed since its announcement and remains a durable fabric for the future. In traditional informed consent cases, an injured patient alleges that the physician failed to reveal some pertinent information, and that the patient would not have consented to the course of treatment if the pertinent information was disclosed. *See, e.g.*, *Kokemoor*, 199 Wis. 2d at 641-47 (physician failed to adequately explain morbidity rates and the physician's lack of experience performing the particular procedure); *Martin*, 192 Wis. 2d at 167-69 (the informed consent discussion did not reveal the availability of a CT scanner and the unavailability of a neurosurgeon at the particular hospital); *Scaria*, 68 Wis. 2d at 3-9 (physician failed to inform patient that dye used for x-rays could cause paralysis or death). Thus, our law has framed the cause question essentially as, "Would a reasonable patient have acted differently if the

informed consent discussion had occurred?" *See Martin*, 192 Wis. 2d at 182.

¶ 38. However, in this type of case the underlying rationale for the objective test, as noted above, is not implicated. The traditional informed consent case necessarily requires a fact finder to do more than find facts; it requires the fact finder to be prophetic. The fact finder is not only asked to determine what actually did happen but is also asked to determine what would have happened if the informed consent discussion had occurred. The fact finder is asked to construct a puzzle with pieces missing and, where missing, to create them so that the puzzle is complete.

¶ 39. Yet, in this case, the fact finder is asked only to determine what did occur and to put the existing pieces of the puzzle together. Janice does not contend that she did not have adequate information about her delivery options so that, if she had more information, she would have chosen the cesarean delivery. Her claim is based on Figge's failure to conduct an informed consent discussion which deprived her of the opportunity for her choice of treatment after she clearly expressed her withdrawal of consent for the VBAC.

¶ 40. In this type of informed consent case where the issue is not whether she was given the pertinent information so that her choice was informed, but rather whether she was given an opportunity to make a choice after having all of the pertinent information, the cause question is transformed into, "What did the patient himself or herself want?" In these cases, the objective test is not needed and may lead to absurd results. It is not needed because the danger it alleviates —

relying on an injured plaintiff's testimony to determine what would have occurred — does not exist because the fact finder is not asked to determine what would have occurred but only what did occur. It can lead to absurd results when the known and concrete choice of the actual person may well be ignored if it does not comport to what the hypothetical reasonable person would have chosen.

¶ 41. Having determined above that Janice did withdraw her consent and that her withdrawal triggered Figge's duty to have another informed consent discussion, by applying the subjective test we further conclude that had Janice been given the opportunity for a choice in treatment she would have chosen the cesarean delivery. Our conclusion is based not on speculation but on the record and factual findings of the circuit court. There can be no serious disagreement that Janice stated that she wanted the cesarean delivery. Figge's testimony indicates that he knew Janice wanted the cesarean delivery. Further, the circuit court found that she already had all of the necessary information and that "if the choice had been put to her squarely she would have opted for a [cesarean] section." Applying the objective test to a case such as this would result in the evisceration of Janice's actually expressed and understood choice of treatment in favor of what the hypothetical reasonable person would have chosen. When we actually know what was chosen based on the disclosure of all of the pertinent information, we need not engage in the hypothetical exercise of what the reasonable person would have chosen.

¶ 42. In summary, we determine that Janice withdrew her consent to a vaginal delivery. Because alternative viable

modes of medical treatment existed at that time, her withdrawal constituted a substantial change in circumstances obligating Figge under Wis. Stat. § 448.30 to conduct a new informed consent discussion and affording Janice the opportunity for a choice of treatment. Figge's failure to conduct such a discussion deprived Janice of the opportunity to proceed with her actual and clearly expressed choice, a cesarean delivery. In applying the subjective test to causation, we conclude that the plaintiffs' damages flowed from Figge's failure to conduct the informed consent discussion. Accordingly, we affirm the court of appeals.

*By the Court.* — The decision of the court of appeals is affirmed and the cause remanded to the circuit court to determine damages.

## APPENDIX B — OPINION OF THE WISCONSIN COURT OF APPEALS DATED AND DECIDED FEBRUARY 17, 1998

Kimberly SCHREIBER, a minor by her Guardian ad Litem, John Krueger; Gerald Schreiber and Janice Schreiber, Plaintiffs-Appellants,

v.

PHYSICIANS INSURANCE COMPANY OF WISCONSIN; Paul K.H. Figge, Jr., M.D.; Wisconsin Patients Compensation Fund, Defendants-Respondents,†

STATE of Wisconsin and Employers Health Insurance Company, Defendants.

Court of Appeals

*No. 96-3676. Oral argument October 16,1997. — Decided February 17, 1998.*

(Also reported in 579 N.W.2d 730.)

* * *

Before Cane, P.J., Myse and Hoover, JJ.

CANE, P. J. Kimberly Schreiber and her parents, Janice and Gerald Schreiber, appeal from a judgment dismissing their claim that Dr. Paul K. H. Figge, Jr., violated Janice's right to informed consent. The Schreibers contend the trial

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† Petition to review granted.

court erred by concluding that Janice was not entitled to choose a cesarean section in the midst of childbirth, and by holding that Figge had no duty to either inform Janice of changes that occurred during labor or to obtain her consent to vaginal delivery after those changes occurred. We conclude that under the specific facts of this case Figge violated his duty under the informed consent statute by refusing to comply with Janice's request for a cesarean. We therefore reverse the judgment and remand the matter to the trial court for a determination of damages.

It is helpful to state at the outset what this case is and is not about. This is not a case establishing a right to treatment on demand. This is also not a case in which the doctor is ethically opposed to a requested treatment, nor is it a case in which the requested treatment falls outside the doctor's practice and experience. Rather, this case involves a doctor who ignores a patient's choice between two medically viable treatment options.

The trial court's findings of fact are substantially undisputed.[1] Prior to the labor that lies at the heart of this case, Janice had two children by cesarean. The first cesarean was performed because of insufficient progress seventeen hours after Janice went into labor. The second cesarean was performed because it was then standard medical procedure to do elective repeat cesarean births. Figge performed both of these procedures.

When Janice became pregnant with Kimberly it was becoming more medically acceptable to attempt a vaginal

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1. This case was tried to the court without a jury.

birth after cesarean (VBAC). Janice met with Figge to discuss the alternatives and, after being given a choice between a cesarean and a VBAC, elected the VBAC. Figge testified at trial that he told Janice that her vaginal delivery would be treated like any other labor, and that a cesarean would be performed if medically indicated.

Janice began labor and was admitted to the hospital shortly after 4 a.m. Figge first saw her at about 8 a.m., and at that time Janice told him that she had changed her mind and wanted a cesarean. Figge did not grant her request. At about 8:30 a.m., Figge concluded that Janice's VBAC delivery was not progressing as fast as he would like and he therefore performed an amniotomy, the breaking of the mother's amniotic fluid sac. Janice thereafter began to experience severe upper abdominal pain unlike any she had felt in her prior deliveries, and that she did not associate with her contractions. She was given pain medication throughout the remainder of her labor with limited success.

At 1 p.m. Figge returned to Janice's room to examine her. He concluded that she was making insufficient progress in labor, and tried but failed to discern the cause of her pain. Although Figge felt he could not completely rule out two potentially harmful causes of the pain, uterine rupture or placental separation,[2] he concluded from his examination that the pain did not indicate any impending danger to the mother or child. In arriving at this assessment, Figge also relied on the fact that in his experience at least one or two

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2. This occurs when the placenta detaches from the uterine wall.

patients a year similarly suffered from undiagnosed pain, and that such pain always resolved itself on the baby's birth.

At about this time Janice made her second request for a cesarean, and Figge responded that he wanted to give the labor some additional time. Janice complained to Figge about her pain, and again requested a cesarean. Figge responded something to the effect that if he "gave every woman who was in labor who asked for one a section, they'd all do it." Janice felt intimidated by Figge's abrupt attitude, and further that they were not "on the same team." In her weakened condition Janice did not pursue the matter further.

Figge testified that while he knew that Janice was experiencing abdominal discomfort and irregular contractions, and while he felt that Janice would have chosen a cesarean if given the choice,[3] he did not grant her

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3. The trial transcript reads:

> Q. And you encouraged her to continue on with the trial of labor at that point?
>
> A. I explained to her what I thought the situation was and what we could do to further ascertain information regarding that, and I did not think that it was unsafe to proceed.
>
> Q. You fully recognized at the time that you had that conversation with her from what you could tell of her demeanor and where she was at in this process that had she — had you given her the choice of going to a cesarean or to continue on with a vaginal delivery that she would have opted for the cesarean, correct?

(Cont'd)

request because he felt that a cesarean was not medically indicated at the time. Figge also testified, however, that he would have performed the procedure if Janice had persisted in requesting it.

About 2 p.m. it became clear to Figge that Janice was in a "hypotonic" pattern, which meant that she was not going to make progress with labor. Figge testified that there were two alternatives at this time: to correct the problem with Pitocin, a labor-inducing drug, or perform a cesarean. Although the Schreibers had recently requested a cesarean, Figge encouraged them to hang on, and testified that he believed they acquiesced in his decision because they stopped resisting his recommendation to wait.

Janice was then given Pitocin to stimulate the labor process. Pitocin was administered in increasing amounts until 3:40 p.m., when the fetal heart beat dropped. Shortly after 4 p.m. an emergency cesarean was performed, and Kimberly was born a spastic quadriplegic. It is stipulated that had Kimberly been born by cesarean prior to 3:29 p.m. she would have been born healthy and normal.

The Schreibers' initial claim against Figge alleged both medical malpractice and a violation of the informed consent

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A. Being in labor, being uncomfortable, she would have done it just simply because of discomfort.

Q. In any event, it was apparent to you that she would have done so?

A. That's correct.

statute. Prior to trial, however, the Schreibers dropped their medical malpractice claim. Our inquiry on appeal therefore does not concern whether Figge's treatment was appropriate, but only whether the Schreibers have a successful claim under the informed consent statute.

The trial court found that Janice had given her informed consent to the VBAC prior to labor, a finding not challenged on appeal. The court also concluded that Figge had no duty to obtain a new informed consent during labor. The court determined that such a duty would only arise if the medical situation changed in such a way as to increase the risks involved. While acknowledging that a cesarean was medically viable at the time Janice requested one, the court determined that there was no change in the situation sufficient to trigger a new duty to obtain Janice's informed consent.

For purposes of appeal, the trial court addressed additional questions that its judgment otherwise made unnecessary. First, the trial court found that Janice was denied a choice among treatments that afternoon. The court noted that Janice's "consent was not solicited and it was not obtained." Further, the court found that Janice would have opted for a cesarean that afternoon if Figge had given her a choice. The court believed that Janice's failure to pursue it because of her stress, discomfort, and perception that Figge's attitude was brusque was entirely credible. Second, the court found that the Schreibers had not established any causation between an assumed informed consent violation and subsequent damages. The trial court then dismissed the Schreibers' claims. The Schreibers appeal.

*Appendix B*

The Schreibers contend that they were denied the right to informed consent when Janice's requests for a cesarean were refused. They claim that under the informed consent statute Figge was not permitted to ignore Janice's clear request for a change in medically viable treatments.[4] Figge responds that he met his informed consent obligations because Janice initially chose the VBAC procedure and never actually withdrew her consent to that procedure, and further argues that a cesarean was not a medically viable alternative when Janice requested it.

Our standard of review in this case is straightforward: the trial court's factual findings are reviewed under a clearly erroneous standard, and we will give due regard to that court's ability to assess witness credibility. Section 805.17(2), STATS. Such factual findings will be upheld as long as they are supported by any credible evidence or reasonable inferences that can be drawn therefrom. *Estate of Cavanaugh v. Andrade*, 202 Wis. 2d 290, 306, 550 N.W.2d 103, 110 (1996). The trial court's conclusions of law, however, are entitled to no deference, and are reviewed by this court under a de novo standard. *Ball v. District No. 4 Area Bd.*, 117 Wis. 2d 529, 537, 345 N.W.2d 389, 394 (1984).

The Wisconsin informed consent law states:

> Any physician who treats a patient shall inform the patient about the availability of all alternate,

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4. In the alternative, the Schreibers argue that Figge at least had a duty to either provide additional information or to clearly offer her a choice. Our conclusion that Figge could not refuse Janice's request makes resolution of these issues unnecessary.

viable medical modes of treatment and about the benefits and risks of these treatments. The physician's duty to inform the patient under this section does not require disclosure of:

(1) Information beyond what a reasonably well-qualified physician, in a similar medical classification would know.

(2) Detailed technical information that in all probability a patient would not understand.

(3) Risks apparent or known to the patient.

(4) Extremely remote possibilities that might falsely or detrimentally alarm the patient.

(5) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.

(6) Information in cases where the patient is incapable of consenting.

Section 448.30, STATS. This statute imposes on physicians, before they subject their patients to medical treatment, the duty to explain all alternate, viable procedures to the patients and to warn them of any material risks or dangers inherent in or collateral to the proposed treatment. This is required to enable the patient to make an intelligent and informed choice about whether to follow the physician's recommendation or to select some other medically acceptable treatment alternative. *Martin v. Richards*, 192 Wis. 2d 156, 173-74, 531 N.W.2d 70, 78 (1995) (citing

*Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 12-13, 227 N.W.2d 647, 653-54 (1975)).[5]

Where there are two or more medically acceptable treatment approaches to a particular medical problem, the informed consent doctrine, medical ethics, and the standard of care all provide that a competent patient has the absolute right to select from among these treatment options after being informed of the relative risks and benefits of each approach. Basic to the informed consent doctrine is that a physician has a legal, ethical and moral duty to respect patient autonomy and to provide only authorized medical treatment. *See Martin*, 192 Wis. 2d at 169, 531 N.W.2d at 76; *see also In re Guardianship of L.W.*, 167 Wis. 2d 53, 68, 482 N.W.2d 60, 65 (1992) (recognizing right to self-determination). The corollary to this principle is that it is inappropriate for physicians to pursue a treatment alternative other than the one to which their patient has given consent. This means that unless the patient consents to the physician's recommended treatment approach, the physician may not proceed with that approach even if the physician personally believes the recommended approach to be in the patient's best interests.[6] *See Bankert v. United States*, 937 F.Supp. 1169, 1173 (D. Md. 1996).

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5. In 1981, the Wisconsin legislature codified the Scaria standard, *Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 227 N.W.2d 647 (1975), in § 448.30, STATS. *See* Laws of 1981, ch. 375, § 2 (effective May 7, 1982).

6. The dissent suggests this opinion compels a doctor to undertake a course treatment the doctor believes is medically

(Cont'd)

*Appendix B*

The doctrine of informed consent "stems from the fundamental notion of the right to bodily integrity: '[e]very human being of adult years and sound mind has a right to determine what shall be done with his [or her] own body.' " *Martin*, 192 Wis. 2d at 156, 531 N.W.2d at 76 (quoting *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914), *overruled on other grounds by Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957)). The Wisconsin informed consent statute seeks to achieve this goal of patient autonomy by insuring the patient has sufficient information to allow for a meaningful choice among medically viable treatments. *Id.* at 174-75, 531 N.W.2d at 78 (the doctor must provide information "reasonably necessary for a patient to intelligently exercise his or her *choice* regarding medical treatment.") (Emphasis added.)

The deference *Martin* pays to the patient's right to choose her or his treatment is important because it demonstrates that the informed consent statute protects more than merely the patient's right to obtain information. It

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inadvisable. We are reluctant to enter into a debate as to whether Figge believed it was medically inadvisable to perform a cesarean. It is our opinion that under the informed consent doctrine, a doctor's personal belief as to the best approach cannot outweigh the patient's right to select a medically viable treatment. In any event, our reading of his testimony is that Figge was willing to perform a cesarean only if he felt it would be safer than continuing with labor. He felt it was his "obligation to try and deliver her safely vaginally" unless something occurred to indicate that it would be safer to perform a cesarean. However, at no time did he state that it would have been medically inadvisable to perform the cesarean.

would be an absurd result indeed if we were to hold that a doctor could meet his or her obligations under the informed consent statute simply by providing information to the patient while ignoring the patient's ultimate choice.[7] Therefore, in addition to protecting the patient's right to obtain information, the informed consent statute must protect the patient's right to choose a medically viable treatment and have that choice respected by her or his doctor.

We further believe that this right to determine one's own treatment and have that choice respected applies regardless of when the choice is made. A competent patient's right to select from among medically acceptable treatment alternatives also encompasses the right to change one's mind about the treatment approach selected. "A competent patient who has had two prior cesarean sections has the right to consent or withhold consent to a trial of labor." *See generally Bankert*, 937 F.Supp. at 1174. There is nothing about pregnancy or the onset of the labor process that automatically renders a woman incapable of rational thought or unable to participate in competent decision-making with respect to which medically viable treatment will be followed.

The facts of this case reveal that Figge failed to respect Janice's right to choose her treatment. The trial court found that Janice at least three times requested a change in

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7. "[I]t is a fundamental rule of statutory construction that any result that is absurd or unreasonable must be avoided." *State ex rel. Reimann v. Circuit Court for Dane County*, 214 Wis. 2d 604, 571 N.W.2d 385, 391 (1997).

treatment; that the treatment sought was medically viable; that Janice's explanation for ceasing in her efforts to exercise her choice was "entirely credible"; and that Janice would have chosen a cesarean if Figge had offered her a choice. Under these circumstances Figge could not ignore Janice and substitute his own choice for hers.

The more difficult question for us is whether Janice's right to choose and control her treatment prevented Figge from refusing to perform the cesarean when she requested it. Keeping in mind that a cesarean remained a medically viable alternative, we conclude that under the specific facts of this case Figge could not refuse the request.[8] Figge had a duty to either perform the cesarean or to obtain Janice's consent to continue with the vaginal delivery when she requested the medically viable alternative treatment.

We do not believe our decision today will lead us, as Figge and the dissent suggest, toward the perceived dangers of a treatment on demand system. Nor does our decision raise any additional complexities in a doctor-patient relationship. To show this, it is helpful to again state what this case is not. First, this is not a case in which a doctor is ethically opposed to performing a certain medical treatment. Figge routinely performed cesareans as a part of his medical practice, including two specifically with Schreiber prior to this pregnancy. Further, Figge had initially given Janice

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8. We do not address whether Figge could have also met his informed consent duty under these circumstances by finding a doctor willing to perform the cesarean, because that argument was not raised.

the opportunity to elect a cesarean prior to labor, and testified that he would have performed one during labor if Janice had persisted in demanding one. Second, for the same reasons, this is not a case in which the requested medical treatment falls outside the doctor's practice and experience.

Instead, this is a case involving a patient who has been given a free choice by her doctor between two medically viable treatment options prior to labor, initially chooses one, but then changes her mind in the face of an unexpected change of circumstances that is inconsistent with or outside the patient's previous experience in similar circumstances. The doctor, although perfectly able and willing to follow the patient's wishes, and although the patient chose a medically viable alternative that had been offered to her by this doctor earlier, nonetheless ignored his patient and substituted his own choice for hers.

We also believe that another critical fact involved in this case sufficiently limits our holding: Janice was in labor at the time she made her request. As Figge points out in his brief, this is a "unique" case because labor involves a lengthy and painful process that the patient undergoes without a general anesthetic. Because of this critical fact, we must affirm Janice's right to choose a cesarean. First, Janice's labor obviously limited her ability to search for and find a doctor willing to perform the requested treatment.[9] Second, Janice's labor and painful condition

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9. The record indicates that Janice's upper abdominal pain during labor was so severe at times that she could not get out of bed without assistance.

limited her ability to continually demand a change in treatment, as Figge expected her to do. Third, Janice could not be expected to expressly withdraw her consent to the VBAC until she could find a doctor willing to perform a cesarean. Therefore, we cannot conclude, as Figge suggests, that there was no informed consent violation in light of Janice's failure to clearly withdraw her consent to the VBAC. She practically could not do so until it became clear that Figge or another doctor would honor her request for a cesarean.

Figge offers three reasons why we should not hold that his refusal to abide by Janice's request violated her right to informed consent. First, he disputes the trial court's factual finding that a cesarean was a medically viable form of treatment when Janice requested it. We see little merit to this argument. Most importantly, Figge's view on appeal would directly contradict the parties' stipulation that Kimberly would have been born healthy and normal if the cesarean had been performed before 3:29 p.m. Furthermore, Figge's own testimony that he would have performed a cesarean if Janice had continued to demand the procedure indicates that the procedure remained a medically viable treatment option. Finally, because a cesarean was obviously viable at both ends of the timeline, at the beginning during the prenatal conference and again at the end when it was actually performed, it could reasonably be inferred that this treatment was also viable throughout the timeline. We therefore uphold the trial court's finding because it is supported by credible evidence.

Figge next argues that he was within his rights to make recommendations to Janice,[10] and that Janice appeared to acquiesce because she stopped making demands for a cesarean. We affirm the trial court's implicit finding that Janice did not acquiesce. The trial court found that Janice was not given a choice and, further, that if she had been given a choice she would have elected a cesarean. This finding is supported by credible evidence. As the trial court noted, Janice's failure to pursue the matter after making three requests was entirely credible in light of Figge's brusque demeanor and her considerable pain.

While we agree that a doctor can, and indeed should, make treatment recommendations, this responsibility cannot be substituted for providing the patient with a meaningful choice. A doctor should not be permitted to wear down a patient by continually advancing the doctor's position, nor should a doctor be permitted to stand behind an incapacitated patient's inability to surmount a brusque, dismissive demeanor. It is also important to recall that Figge avoided offering Janice a choice that afternoon even though it was apparent to him that she would have continued to ask for a cesarean.[11] On these facts we conclude that the trial court's implicit finding of no acquiescence is supported by credible evidence.

Figge's final argument is that even if he violated Janice's right to informed consent, there are no damages.

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10. *See Martin v. Richards*, 192 Wis. 2d 156, 181-82, 531 N.W.2d 70, 81 (1995).

11. *See* note 3, *supra*.

In support of his argument, Figge refers us to both Wisconsin case law establishing an objective standard of causation in informed consent cases and the trial court's finding that a reasonable patient in Janice's position would not have elected a cesarean. We are not persuaded.

We begin by acknowledging that all Wisconsin informed consent cases addressing the causation issue have followed an objective test. *See, e.g., Scaria*, 68 Wis. 2d at 12, 227 N.W.2d at 654-55. We do not believe, however, that these cases control the outcome in this case because they addressed a question different from the one before us. Notably, all these prior informed consent cases focused on whether the information given to the patient was sufficient. When those cases concluded that the information given was insufficient, the court was required to determine whether that violation actually caused the damages complained of. In other words, as the *Martin* court explained, the question was then whether it "would have made a difference" if the patient was given the correct information. *Id.* at 182, 531 N.W.2d at 81.[12] We do not believe that such an inquiry is necessary in this case.

As we have noted, Wisconsin adheres to the "fundamental notion of the right to bodily integrity." *Id.* at 169, 531 N.W.2d at 76. We are unwilling to apply an objective standard in a case such as this where the patient clearly expressed her treatment choice, and where that

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12. This causation question is generally answered by a finding that a reasonable person would not have consented to the doctor's proposed treatment had the patient been fully informed of all available treatments. *See* Wis J I — Civil 1023.3.

choice was simply ignored. We are unwilling to allow a doctor to hide behind the question of what a "reasonable" patient would have done where the doctor fails to respect a patient's choice among medically viable treatment alternatives, and where that failure causes damages. Because the parties stipulated that Kimberly would have been born healthy and normal if Figge had not refused Janice's request that afternoon, we conclude that damages resulted from this breach of the informed consent statute.

We therefore conclude, on the specific facts before us, that Figge could not refuse Janice's request for a cesarean. His refusal to abide by Janice's fundamental right to choose her own method of treatment constitutes a violation of the Wisconsin informed consent statute, and damages flowed from that violation without regard to the "objective" standard of causation.

*By the Court.* — Judgment reversed and cause remanded for a hearing on damages.

MYSE, J. (*dissenting*). I enthusiastically endorse the majority's discussion of the patient's right to determine her or his course of treatment. However, I respectfully dissent from the majority's holding that under certain circumstances a doctor can be compelled to undertake a course of treatment the doctor believes is medically inadvisable. This is not, and cannot be, the law. It is neither supported by the informed consent statute nor sensibly grounded in public policy.

*Appendix B*

The informed consent statute is as follows:

> Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments. The physician's duty to inform the patient under this section does not require disclosure of:
>
> (1) Information beyond what a reasonably well-qualified physician in a similar medical classification would know.
>
> (2) Detailed technical information that in all probability a patient would not understand.
>
> (3) Risks apparent or known to the patient.
>
> (4) Extremely remote possibilities that might falsely or detrimentally alarm the patient.
>
> (5) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.
>
> (6) Information in cases where the patient is incapable of consenting.

Section 448.30, STATS. This statute codified the standard set forth in *Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 227 N.W.2d 647 (1975). *See Martin v. Richards*, 192 Wis. 2d 156, 173-74, 531 N.W.2d 70, 78 (1995).

*Appendix B*

The Wisconsin informed consent statute cannot be fairly read to compel either Figge or any other doctor to perform a treatment the doctor does not believe is medically indicated. In interpreting a statute our goal is to ascertain the intent of the legislature. *UFE, Inc. v. LIRC*, 201 Wis. 2d 274, 281, 548 N.W.2d 57, 60 (1996). The first step of this process is to look at the language of the statute. *Id.* If the plain meaning of the statute is clear, we should simply apply that meaning to the facts before it. *Id.* at 281-82, 548 N.W.2d at 60.

The plain language of the informed consent statute merely requires the doctor to provide the patient with information sufficient to allow the patient to either consent or withhold consent to the doctor's proposed medical treatment. This much was said in *Scaria*. There the court stated:

> The right to be recognized and protected is the right of the patient to consent or not to consent to a proposed medical treatment or procedure.
>
> . . . .
>
> In short, the duty of the doctor is to make such disclosures as appear reasonably necessary under circumstances then existing to enable a reasonable person under the same or similar circumstances confronting the patient at the time of disclosure to intelligently exercise his right to consent or to refuse the treatment or procedure proposed.

*Id.* at 12-13, 227 N.W.2d at 653-54. The plain language of the informed consent statute and *Scaria* demonstrate that there was no intent to require a doctor to perform medical treatment on demand. Figge should not be held liable for failing to do so here.

The majority attempts to create a right to treatment on demand in this case by relying on the fundamental notion of the right to bodily integrity. Quoting from *Martin*, the majority adopts the position that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his [or her] own body." This is rather ironic because the majority proceeds to compel a doctor to perform a treatment the doctor does not believe is medically indicated and does not want to do. In the instant case, Figge determined that "there was no real danger" as a result of Janice's upper abdominal pain, and therefore believed "that there was no real indication to proceed to a cesarean" when Janice requested it. Figge's refusal to perform the cesarean was based on his belief that it was bad medical practice to perform a cesarean based on complaints of pain alone. If his medical judgment concerning the appropriateness of a cesarean was incorrect, Figge may be liable in a medical malpractice claim. But Figge's refusal to carry out a treatment that he believes is contraindicated does not implicate the informed consent statute.

The informed consent statute requires the doctor to explain all viable, medical modes of treatment. This recognizes that there may be a number of feasible approaches to a specific medical problem. But simply because a medical procedure is feasible does not make

such a procedure preferable or even desirable. We have recognized this in several cases by reaffirming the doctor's right to make recommendations and even persuade the patient to follow the doctor's superior medical judgment. *See, e.g., Martin*, 192 Wis. 2d at 181, 531 N.W.2d at 81 ("The doctor might decide against the alternate treatments or care, [she or] he might try to persuade the patient against utilizing them, but [she or] he must inform them when a reasonable person would want to know."). Of course, the patient is entitled to know about and even to elect other medical procedures that are available but not recommended. I do not believe, however, that this right encompasses the right to compel a given doctor to perform a specific treatment. The doctor should retain the right to refuse to follow a course of treatment that contravenes the doctor's opinion as to proper medical practice and procedure.

Contrary to the Schreibers' argument, affirming this right of the doctor does not correspondingly render meaningless the right of the patient to direct her or his treatment. If a doctor refuses to follow the patient's choice of treatment the patient remains able to seek another doctor willing to accept the choice of treatment. While I acknowledge that under certain circumstances a patient may not be able to effectively choose among all treatment options, there is nothing in the informed consent statute to suggest that a doctor must follow the patient's request in those cases. By refusing to include such a provision in the statute I believe the legislature intended to balance the doctor's right to control one's own medical practice with the patient's right to control one's own treatment.

*Appendix B*

I further believe that the majority decision is bad public policy. Such a decision can only work to raise additional complexities in an already complex system of legal entanglements with the patient-doctor relationship. By limiting its result to the facts, the majority gives little guidance to doctors with respect to this new duty. It is unclear when a doctor will have to follow a patient's demands for treatment, and the majority opinion establishes no criteria that will assist the doctor in making this determination. For all these reasons, I would hold that Figge violated no duty by refusing to perform the cesarean at the time it was requested.

## APPENDIX C — AMENDED ORDER FOR JUDGMENT AND JUDGMENT OF THE CIRCUIT COURT FOR THE STATE OF WISCONSIN, ONEIDA COUNTY DATED NOVEMBER 20, 1996 AND FILED NOVEMBER 22, 1996

STATE OF WISCONSIN
CIRCUIT COURT
ONEIDA COUNTY

Case No. 92-CV-298

KIMBERLY SCHREIBER, a minor by her Guardian ad Litem, John W. Krueger; GERALD SCHREIBER; and JANICE SCHREIBER,

Plaintiffs,

v.

PHYSICIANS INSURANCE COMPANY OF WISCONSIN, INC., a Wisconsin corporation; PAUL K. H. FIGGE, JR., M.D.; WISCONSIN PATIENTS COMPENSATION FUND, a Wisconsin corporation; EMPLOYERS HEALTH INSURANCE COMPANY, a Wisconsin corporation; STATE OF WISCONSIN, a sovereign body,

Defendants.

### AMENDED ORDER FOR JUDGMENT AND JUDGMENT

The above-captioned action having been tried to the Court by stipulation after selection of a jury but before

testimony, with all parties waiving their right to a Jury trial as to all issues, and the parties further stipulating to a bifurcation of the trial with the liability determination only to be made by the Honorable James W. Karch, and the Court having heard and considered all of the evidence presented during said trial which began on April 26, 1996 and ended on May 6, 1996, and the parties providing post trial briefs and other submissions with the final submissions from the parties having been received by the Court on July 26, 1996; and the Court thereafter having considered the evidence received during the course of the trial and upon due consideration, pursuant to the provisions of Section 805.17, Wisconsin Statutes, rendered and entered its DECISION, FINDINGS OF FACTS, CONCLUSIONS OF LAW AND JUDGMENT dated September 24, 1996, and the Court having previously ordered that the Plaintiffs' Complaint be dismissed on its merits and with costs, and the Clerk of Court having approved costs in the sum of $7,734.04, and based upon the above and foregoing, and on the Motion of Randall J. Sandfort, Attorney for Defendants, Dr. Paul K. H. Figge, Jr., Physicians Insurance Company of Wisconsin, Inc., and Wisconsin Patients Compensation Fund;

IT IS HEREBY ADJUDGED, ORDERED AND DECREED that the Complaint of the Plaintiffs, and all causes of action stated therein, be and the same hereby is dismissed on its merits, with prejudice, and that the Defendant, Physicians Insurance Company of Wisconsin, Inc., have and receive judgment against the Plaintiffs, Gerald Schreiber and Janice Schreiber, for its costs and disbursements as permitted by law in the sum of $7,734.04.

*Appendix C*

Dated at Baraboo, Wisconsin this 20th day of November, 1996.

BY THE COURT:

s/ James W. Karch
Honorable James W. Karch
Reserve Judge

## APPENDIX D — DECISION, FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT OF THE CIRCUIT COURT FOR THE STATE OF WISCONSIN, ONEIDA COUNTY DATED SEPTEMBER 24, 1996

STATE OF WISCONSIN
CIRCUIT COURT
ONEIDA COUNTY

Case No. 92 CV 298

KIMBERLY SCHREIBER, a minor, by her Guardian ad Litem, John W. Krueger, GERALD SCHREIBER, and JANICE SCHREIBER,

vs.

PHYSICIANS INSURANCE COMPANY OF WISCONSIN, INC., a Wisconsin corporation, PAUL K. H. FIGGE, JR., M.D., WISCONSIN PATIENTS COMPENSATION FUND, a Wisconsin corporation, EMPLOYERS HEALTH INSURANCE COMPANY, a Wisconsin corporation, and STATE OF WISCONSIN, a sovereign body,

Defendants.

DECISION,
FINDINGS of FACT,
CONCLUSIONS of LAW
and
JUDGMENT

*Appendix D*

## I. POSTURE OF CASE

This medical malpractice case was tried to the court by stipulation after the selection of a jury but before any testimony. The parties agreed to waive their right to a jury trial as to all issues, with the liability determination only to be made by the undersigned judge and any necessary damage findings to be made in the manner recited in detail into the record. Testimony was then taken on six days, beginning April 26, 1996, and ending May 6, 1996.

Following the close of testimony briefs and proposed Findings and Conclusions have been provided, with the final submissions received on July 26, 1996.

## II. SUMMARY OF FACTS

Prior to the incident forming the basis for the suit, the plaintiff Janice Schreiber had had two children, each delivered by cesarean section, on November 9, 1981, and February 13, 1984. The first section was due to insufficient progress in labor and the second by advance election in accordance with the general practice at the time.

In early 1988, when the plaintiff was again expecting, vaginal deliveries following sections were commonly being attempted, and during the prenatal consultation the decision was made to do so here, that is, to attempt a VBAC, a vaginal birth after cesarean.

The defendant Dr. Paul Figge provided care to the plaintiff throughout all three pregnancies.

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Mrs. Schreiber began experiencing labor pains in the evening of June 24, 1988, and was admitted to the hospital at 4:10 A.M. on June 25, 1988. Dr. Figge first saw her at the hospital in a corridor at about 8:00 A.M. and she told him that she had changed her mind and would like to go with a section. His response was that they'd go to her room and he would check her out, which was done, and there was no further discussion at that point regarding the matter.

The progress in her dilation was limited, and Dr. Figge then performed an amniotomy, a breaking of the amniotic fluid sac, an aid to the progress of labor. Shortly thereafter the plaintiff began experiencing severe upper epigastric pain that she had not had in her prior deliveries and that she did not associate with her contractions. Pain medication was first administrated at 9:30 A.M., with limited relief provided. In dispute is whether Dr. Figge again saw her shortly after this time.

At 1:00 P.M. Dr. Figge returned to her room, determined that she had made insufficient progress, and attempted to ascertain the source of the pain. He conducted an examination and concluded that the pain was not related to a factor that would suggest impending danger, although he could not determine the precise cause. He then directed the administration of Pitocin in an attempt to stimulate her labor.

At that point the plaintiff was asking for a section, but the defendant told her and her husband, the plaintiff Gerald Schreiber, that she should continue to attempt to achieve her goal of vaginal delivery.

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At 3:40 P.M. the fetal heart beat dropped and a section was performed at 4:03 P.M., but a catastrophic injury had already occurred, depriving the fetus of oxygen and resulting in the child, the plaintiff Kimberly Schreiber, being a spastic quadriplegic.

The parties have stipulated that if a cesarean section had been performed prior to 3:29 P.M., Kimberly would be a healthy and normal child.

## III. ISSUES

When this action was commenced on September 25, 1992, the complaint made general allegations regarding negligence on the part of Dr. Figge. However, by correspondence of January 4, 1996, and March 21, 1996, confirmed subsequently on the record, plaintiffs' counsel advised that they were no longer pursuing any medical mismanagement claim and that the only theory of negligence was directed to informed consent.

The parties are in agreement that in connection with the prenatal election for a VBAC, the initial inquiry is whether Dr. Figge was negligent in failing to make such disclosures to Janice Schreiber as would enable a reasonable person under the circumstances confronting her to exercise the right to elect between an attempt at vaginal birth and an elective repeat cesarean section.

An affirmative answer to this question is followed by a query as to whether a reasonable person, placed in the position of Janice Schreiber and receiving adequate

disclosures, would not have consented to the attempt at a vaginal birth.

As to the 1:00 P.M. consultation, the plaintiffs present the same two questions relating now to continuing with the attempt at vaginal delivery or trial of labor as opposed to proceeding immediately to a section.

The defendants' position is that Dr. Figge was under no duty to have an informed consent discussion with the plaintiff at this time period so that no other inquiries need to be answered.

As stated, the parties have stipulated as to medical cause.

## IV. RESOLUTION

In summary, I find that the prenatal disclosures were not inadequate and that the defendant had no duty to conduct an informed consent discussion with the plaintiff during labor.

Accordingly I determine that the complaint be dismissed.

## V. AUTHORITIES

Wisconsin cases on informed consent are:

*Trogun v Fruchtman*, 58 Wis.2d 156, 207 N.W.2d 297 (1973)

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*Scaria v St. Paul Fire & Marine Insurance Co.*, 68 Wis.2d 1, 227 N.W.2d 647 (1975)

*Martin v Richards*, 192 Wis.2d 156, 531 N.W.2d 70 (1995)

*Johnson v Kokemoor*, 199 Wis.2d 615, 545 N.W.2d 495 (1996)

*Finley v Culligan*, 201 Wis.2d 611, 548 N.W.2d 854 (Ct App 1996)

*Kuklinski v Rodriguez*, (Ct App 7/2/96, publication ordered 8/27/96)

Section 448.30, Wis. stats. (Codifying *Scaria*)

## VI. DECISION

This has been an unusually difficult case, primarily because of the blurring of the lines between diagnosis or medical management on the one hand and informed consent on the other. The submissions and statements on the record throughout demonstrate this conflict, with the plaintiffs maintaining that their evidence was directed to informed consent, the defendants frustrated from their belief otherwise and my struggling with attempting to properly analyze it.

An example of the difficulty in examining the case efficiently is the plaintiffs' position expressed at page 3 of their post-trial brief and page 1 of their reply post-trial brief

that the true issue in this case is whether or not proceeding to a cesarean section at 1:00 P.M. was a viable medical alternative. Would that the resolution could be that easy. Of course it was; it was beginning at 4:10 that morning. I do not understand the defendants to suggest otherwise.

Another area of concern is in evaluating the credibility of the Schreibers and Dr. Figge. Parties always have a self-interest in their testimony. But here for the Schreibers at least their interest is especially compelling from the devastating loss they have suffered, of a healthy child, and the overwhelming burden they now have in caring for Kimberly.

But, in accord with the principal rationale for the objective nature of the cause test, I am not to permit the plaintiffs' hindsight after a bad result to drive the resolution of the case.

At the same time Dr. Figge's testimony also would be expected to be exculpatory, but I do not view it in the same light.

Plaintiffs suggest a falsus in uno approach to Dr. Figge's testimony based on three separate instances: the claimed 10:30 A.M examination, the cause of the damage to Kimberly and the etiology of the epigastric pain.

I viewed Dr. Figge on the stand and found him to be a credible witness. While I think it more likely than not that the examination did not take place, I accept that Dr. Figge believed that it did when he testified. Likewise I am not

persuaded by the other challenges. I reject the invitation to discount other areas of his testimony.

The initial question for a jury, and likewise for me, as stated at III above, addresses the prenatal information given by Dr. Figge to Mrs. Schreiber. Specifically, the plaintiffs complain that the information conveyed should have included (Plaintiffs' post trial brief, pages 13, 14 and 18):

1. A reference to the possibility of uterine rupture.

2. Advice that once a VBAC was elected, she could not change her mind.

3. The lack of experience of Dr. Figge with multiple VBACs.

4. The 1988 ACOG (American College of Obstetricians and Gynecologists) guidelines not allowing a doctor to encourage a multiple VBAC.

5. The risk for a section after a trial of labor being greater than that for an elective repeat section.

6. A lack of sufficient experience in the literature to support the efficacy of multiple VBACs.

I agree that on the record here the possibility of uterine rupture is a topic to be mentioned. There was no particular disagreement with this, even though the risk was extremely slight and no expert professed to have had any any significant personal experience with it happening.

I consider that this was done here. I appreciate that there was a direct conflict in the testimony on this. However, I believe the defendant's account more credible. He testified that he did mention it and in fact that it would be very difficult to talk with a patient about electing a vaginal birth without talking about the reasons for the change in practice in allowing them to attempt a vaginal birth without mentioning uterine rupture.

On the other hand, Mrs. Schreiber, while firm in her position that uterine rupture was never mentioned, nonetheless testified that she did not remember everything said to her about VBACs, and I can well imagine that prior to this episode the topic of a uterine rupture could well be one that would not stay with her.

Plaintiffs assert that the defendant's testimony on this is contradicted by his discovery deposition testimony. I do not agree. Contrary to the assertion on page 8 of plaintiffs' reply brief, he was not asked what he told Mrs. Schreiber. He may have included a reference to her in his answer, but it is not limited to her and there was no follow-up by plaintiffs' counsel.

As to the second point above, I consider that the defendant did not adopt this position. I believe that he did not comply with the plaintiff's 1:00 P.M. request, not because he never permitted a change of mind during labor, but because he believed that she should continue to deliver vaginally, in accordance with the procedure she had initially determined upon.

As to number three, I do not accept that the defendant had to inform her of his lack of experience with multiple VBACs. I consider that this case is readily distinguishable from *Johnson* where the doctor's lack of experience in the particular surgery involved was held to be included within the information to be given the patient. But underlying that conclusion, besides the extreme fact situation involved, was compelling testimony about the necessity for such experience and the significantly increased risks in being operated upon by one with his limited background.

Here there was no such testimony suggesting the risks were greater because of Dr. Figge's lack of specific experience with multiple VBACs. Rather the credible testimony was that this was more a question of the general competence and experience of the doctor in his obstetric practice, and no one has suggested criticism of Dr. Figge in this regard.

Mrs. Schreiber testified otherwise, of course, but I doubt that a reasonable person would expect to have this information volunteered to them, in view of the absence of any increased risk therefrom.

As to number four, this information would not have been required because it is not accurate. It repeats a position expressed on several occasions in plaintiffs' post-trial submissions that is premised on the ACOG guidelines being mandatory. They are not, of course, as I thought was clearly established during the trial.

Granted, the guidelines recommended that doctors not encourage multiple VBACs, but I am not persuaded that a

patient needs to be advised of that. I do not recall any witness so testifying, nor do plaintiffs point to any.

Items five and six are more nebulous. There was considerable contradictory evidence regarding the relative risks of vaginal versus section after trial of labor versus elective repeat section deliveries. Any expectation that I can resolve this conflict is unrealistic, particularly since I do not find it necessary to do so.

Suffice it to say that I consider that Dr. Figge's discussions with plaintiff regarding the pros and cons on a number of occasions, as she testified to, her testimony that he informed her that one risk was a repeat section, her further testimony that she was aware that there was more of a risk with surgery, and his testimony at pages 21 to 31 of the trial transcript, which I accept, all are sufficient to satisfy his obligation in this regard. As I understood the testimony of the two defense experts at trial, Dr. Cruikshank and Dr. Meier, neither would have provided the information of concern here.

While not necessarily controlling on the point, I particularly note Exhibit 61, an ACOG bulletin of February, 1987, entitled "Vaginal Birth After Cesarean Delivery", a patient information pamphlet for providing to one contemplating a VBAC. No risk of the type under consideration at items five and six appears.

In reference to the overall issue regarding the information conveyed, I conclude that I may consider that Dr. Giles, one of plaintiffs' experts, testified in a discovery

deposition at a point in time where the focus of the plaintiffs' case remained on medical management that he had reviewed the defendant's discovery deposition testimony regarding prenatal informed consent and had no criticism regarding the same. In his trial testimony there is the suggestion that if defendant's version is adopted it would comply, with the rupture risk being the main point of concern. And both Dr. Cruikshank and Dr. Meier suggested approval of the disclosures.

Also from Exhibit 61, the ACOG bulletin, is the advice that the main risk of a VBAC is rupture of the uterine scar, which is more likely if the scar is a classical vertical incision (not the situation here), and that although very uncommon this still may of itself be reason to avoid a VBAC. Further, that a rupture is still possible with a low transverse incision (our situation) but minimizes the risk from it.

I am, of course, to consider this from the point of view of what a reasonable person in similar circumstances to those of Mrs. Schreiber would want to know. However, in view of the expert testimony, I consider appropriate the following from *Scaria,* page 12:

> The disclosures which would be made by doctors of good standing, under the same or similar circumstances, are certainly relevant and material and we surmise would be adequate to fulfill the doctor's duty of disclosure in most instances.

I understand that in retrospect the plaintiff believes that she should have had more information. But in view of her

comfort level with Dr. Figge, as referred to in the next section dealing with cause, I find it unlikely that either she or any other reasonable person would really have considered and weighed all of these matters now complained of.

The burden of proof is on the plaintiffs to satisfy me to a reasonable certainty by the greater weight of the credible evidence, and I cannot determine that the information given by Dr. Figge in the prenatal period was not adequate.

If, however, the answer to this first question should be affirmative, then I consider the resolution of the second question, the legal cause.

I rely here on several aspects of the testimony:

1. Mrs. Schreiber testified that one of the reasons that she decided to choose VBAC was "because I felt really comfortable with what Dr. Figge was telling me" (TT p49), you do have a tendency to believe and follow the advice of your physician (TT p171), and "He had no problem with it at all, and because he had no problem with it at all, I was comfortable with it" (TT p176).

2. Dr. Giles responded to a question as to whether it would have been all right to manage Mrs. Schreiber as a VBAC patient with "Absolutely" (TT p59).

3. Dr. Giles continues to offer patients VBACs "enthusiastically" (TT p13), he strongly recommends them (TT p167), and 70% to 80% of his patients try it (TT p168).

4. Dr. Klaven, plaintiffs' other expert, testified that he would have accepted plaintiff as an appropriate patient (Video Transcript p101), and that in 70% of his cases a repeat section is not even an option, although it is not clear whether this was limited to one prior section mothers (VT p 93). In any event, a VBAC is his standard of delivery for two prior cesareans (VT p102).

I recognize that Mrs. Schreiber testified that she would not have elected VBAC if she had been aware of any of the risks. I would hardly have expected her to say otherwise. But as the case law points out, while her testimony on this is admissible, it may not threaten to dominate the findings. *Scaria.*

With the overwhelming support for VBACs and with her own statements regarding accepting her doctor's advice along with my own perceptions of the general tendency of reasonable people to look to their doctors for guidance and decision-making, as confirmed by the experiences of all of the medical witnesses, I am not persuaded that a reasonable person in her position with adequate information would not have consented to the attempt at vaginal birth.

Turning now to the 1:00 P.M. time period, the critical issue in view of the posture of the case is whether the defendant was bound to conduct an informed consent discussion with the plaintiff at this point.

The plaintiffs claim yes, because of her request for a section and because her changed condition had increased the risks.

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As to the first, this aspect has come up regularly throughout the various conferences and hearings we have had in this case, with plaintiffs' counsel maintaining that the request triggers the application of sec. 448.30.

In plaintiffs' post-trial brief the following appears at page 1:

> Since it is clear that this alternative (a section delivery) was not made available to her at 1:00 p.m., the issue regarding the 1:00 p.m. conference is merely a legal one, did the informed consent duty apply at that time? If it did, then Janice Schreiber had the right to choose. It seems inconceivable that when the patient is requesting the alternative procedure that the informed consent duty would not apply at that time.

—

But how do I determine if the duty existed at that time as invoked by her request? No expert testimony was presented and neither side has provided any authority specifically on point. I have made an exhaustive search and cannot find any anywhere that addresses this concept of a proper response to a request as made here, either by way of initiating an informed consent discussion or otherwise. And this despite the comment appearing in 61 Am. Jur. 2d, Physicians, Surgeons, etc., section 187:

> The doctrine of informed consent has achieved a status in the law of medical malpractice unmatched in speed of growth and commentary.

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Returning to the last sentence of the post-trial brief quote above, I observe that Mrs. Schreiber also made a request for a section at 8:00 A.M. that day which was not observed. It would seem that the same result should obtain in either case, but plaintiffs have not so argued.

I am satisfied to determine that once the procedure elected has been initiated, as here, a request for a change does not thereby require an informed consent discussion. At this point the election has been made and the procedure in progress. As defendant testified, his duty was to manage her labor and to help her achieve her goal as long as it was safe.

The other question presented then is whether in this ongoing procedure the presence of changed circumstances resulting in a change in the risk situation requires a renewed informed consent discussion regarding alternative modes of treatment.

The statute, sec. 448.30, does not provide a clear answer. The cases recited earlier all deal with either proposed surgery or alternative diagnostic or treatment methods. And again, no authority has been submitted, and I have not found any of assistance.

The conclusion I derive from the medical testimony presented is that a substantial change in the circumstances surrounding the patient ought to require a renewed informed consent discussion if there are alternative, viable medical modes of treatment.

The plaintiffs' two experts testified that these changed conditions and thus increased risks were present here.

The defendants' experts, the two already referred to plus Dr. Phelan as well as Dr. Figge, all took the position that the situation had not changed so that a consent discussion was not necessary. The obvious inference is that changed circumstances are in fact significant, which leads to the same position as the plaintiffs'. And this seems to me to be an appropriate conclusion.

Accordingly, I determine that following an informed consent to a specific treatment procedure, once the procedure has commenced, the duty of the doctor is to seek to achieve its goal, but if the situation changes to increase the risks presented to the patient and there are alternative, viable medical modes of treatment available, then a renewed discussion under sec. 448.30 needs to take place.

To consider this for our situation, a more detailed statement of the underlying facts is required.

Mrs. Schreiber began having light contractions at 10:00 P.M. the evening before delivery. She was admitted to the hospital at 4:10 A.M. At 8:50 A.M. Dr. Figge performed the amniotomy. At 9:10 A.M. pain started and at 9:30 A.M. pain medication administered with pain reported at 10:05 A.M. as slightly less. At noted earlier, the pain was reported as severe.

At 12:17 P.M. a different pain medication was administrated with a 12:40 P.M. report of more comfortable

and a 1:05 report of fairly comfortable. Pitocin was started at 1:48 P.M. Subsequently fetal distress was noted and at 4:03 P.M. an emergency cesarean was performed. (Exhibit 1, a time-line presentation from the nursing notes, exhibit 4.)

The plaintiff testified that at the examination by Dr. Figge at 1:00 P.M. she told him she wanted a section and his response was that he wanted to give it more time. She complained about the pain and he replied sharply, "I hear you, Jan." Shortly after that she again asked for a section and he responded, "If I gave every woman who was in labor who asked for one a section, they'd all do it". She felt that he was abrupt on these two exchanges, her feelings were hurt and she "kinda withdrew", not pursuing the matter any further.

Mr. Schreiber described the responses as snapping at her. He further related that on the second request, defendant said that things were ok and they should continue to give it more time.

Both Schreibers made it clear that relief from the pain was the motivation for requesting the section.

Dr. Figge's testimony was substantially in accord. He testified that at 1:00 P.M. she asked for a section and he responded that he'd do an examination and then they would discuss it.

After the exam he told her that there were no indications to proceed with a section at that point and that she should

give it the best chance. He also considered it appropriate to attempt to stimulate labor with Pitocin, which was done.

Dr. Figge testified that while he could not determine the cause of her upper abdominal pain, he was convinced from his examination that it was not related to either placental separation or uterine scar dehiscence, a weakening or partial tear of the scar from a prior section incision, although he could not rule out either with 100% certainty.

It should be noted that in plaintiff's first delivery in 1981 she was experiencing contractions at home for a extensive period of time, as I understood her testimony. She was admitted at 2:00 A.M., had a day of considerable contraction pain, received Pitosin for three hours and at 7:00 P.M. a section was elected.

Plaintiffs claim that there were two changed circumstances: the failure to progress in labor and the inability to ascertain the source of the pain.

None of the defendants' experts considered that either of these constituted such a change as to require a renewed discussion with the plaintiff. In general, they approved the examination made by defendant, agreed with his conclusions and considered that there were no increased risks and that there was no need to advise Mrs. Schreiber that the source of the pain was unknown.

Both of the plaintiffs' experts believed otherwise, that in fact that the circumstances had changed as to both points, and indeed that a section was mandated at that time.

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In this connection I observe that each testified to this effect even with the knowledge that medical management was no longer in the case and presumably with the knowledge also that the court had entered an order in limine precluding any reference to the appropriateness of Dr. Figge's conduct in the management of the medical care provided to the plaintiff. (Giles trial transcript p210; Klavan video deposition transcript pp49, 70 and 72; transcript of motion hearing of April 12, 1996, p3.)

In evaluating the messages I certainly may evaluate the messengers, and in viewing their testimony I may consider their underlying point of view, the belief that defendant was wrong in not performing a section at 1:00 P.M.

As to the lack of progress in labor, I observe that here the plaintiff was in labor at the hospital for nine hours before the section delivery while in her first pregnancy she was in labor at the hospital for 17 hours before delivery by section for failure to progress.

It does not seem unreasonable to me to accept the testimony on behalf of Dr. Figge that the lack of progress was not a changed condition requiring a review of options.

As to the source of the pain, Dr. Figge was convinced it was not a threat to the fetus. He had had previous experience with unexplained pain during labor, and it had gone away after delivery. There was credible testimony from his experts in support of this determination and his conclusion that the risks were not increased.

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Plaintiffs assert that in fact the cause of the pain was a dehiscence which confirms the increase of the risk at 1:00 P.M. But this is entirely conjecture; the cause of the pain was not established by the record at all, in my view.

I am satisfied to find that the circumstances had not changed so that the defendant was not required to obtain renewed consent to the choice of treatment. There was nothing to communicate; the risks had remained the same, as he viewed them.

However, if Dr. Giles and Dr. Klavan are correct, where does that leave us? With a faulty diagnosis, in my opinion, considering the precise nature of the plaintiffs' criticism in this regard.

Dr. Klavan articulates it as:

> . . . his failure to recognize that the trial — that the labor was not progressing was a medical problem, and that he had to rule out a separation of the scar because of the upper abdominal pain and the informed consent, otherwise I had no problem with the care he provided. I thought it was good. (Video transcript p123.)

The plaintiffs' reply post-trial brief at page 38 complains that "He was simply unable to determine the source of the pain", and at page 39 that "The doctor didn't have a clue as to what was causing the pain".

This, it seems to me, is diagnosis, which, of course, is care and treatment and is not in the case.

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As discussed recently in *Finley* at page 628:

> A failure to diagnose is a form of medical malpractice. Citing. A failure to obtain informed consent is another discrete form of malpractice, requiring a consideration of additional and different factors."

I note with interest a statement in Treatise on Health Care Law, published by Matthew Bender, sec. 17.02(2)(a):

> Some claimants have attempted to convert instances of missed or erroneous diagnosis, which properly should be regarded as possible cases of medical negligence, into informed consent claims.

I am satisfied that this is the situation here.

While this concludes the discussion underlying my determinations, it seems appropriate to proceed to consider other factual matters here, in the event an appellate court disagrees with my conclusion that there was no informed consent duty at 1:00 P.M.

I conclude that the consent portion of this dialogue was missing. Plaintiff's consent was not solicited and it was not obtained. Defendants' post-trial brief at page 91 concedes as much, that there was no discussion in the context of a wholly elective choice.

I am also satisfied, as presumably the defendants would agree, that if the choice had been put to her squarely she

would have opted for a section. Her explanation for why she did not pursue it at the time in the stress of her physical discomfort and her perception of the brusque attitude of the defendant is entirely credible.

Thus any inquiry as to the adequacy of the information conveyed to her becomes irrelevant, in my opinion.

However, there may be concern with the next step, if a reasonable person placed in her position and receiving adequate disclosures would not have consented to continue in the attempt at vaginal birth.

From the point of view of Dr. Giles and Dr. Klavan, the obvious answer is yes. But I suggest that neither doctor would have disclosed any information to the patient except to announce that they were headed for surgery.

From the point of view of the defendant and his witnesses, however, the additional risks were minimal and the patient would be encouraged to continue. Taking into account the considerable testimony that without exception demonstrated the overwhelming willingness of patients to accept the recommendations of continuing, the answer here is negative.

## VII FINDINGS OF FACT

1. I adopt as findings of fact the recitations of facts within Sections II and VI above.

2. The defendant Paul K. H. Figge was not negligent in failing to make such disclosures to the plaintiff Janice

Schreiber before the onset of labor was would enable a reasonable person to exercise the right to elect between an attempt at vaginal birth and an elective cesarean section.

## VIII CONCLUSIONS OF LAW

1. I adopt as conclusions of law the legal determinations contained within Section VI above.

2. The defendant Paul K. H. Figge was under no duty under the circumstances to secure the informed consent of the plaintiff Janice Schreiber to a continuation of the trial of labor after its onset.

## IX JUDGMENT

Upon the record and proceedings herein and upon the foregoing Decision, Findings of Fact and Conclusions of Law,

IT IS ORDERED AND ADJUDGED, That the complaint of the plaintiffs herein be dismissed on its merits, with costs.

Dated: September 24, 1996.

BY THE COURT,

s/James W. Karch
James W. Karch, Judge

**APPENDIX E — ORDER OF THE WISCONSIN SUPREME COURT DENYING MOTION FOR RECONSIDERATION DATED APRIL 7, 1999**

**SUPREME COURT**
OF WISCONSIN
**OFFICE OF THE CLERK**
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MARILYN L. GRAVES
CLERK

Date: April 07, 1999

To:

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*Appendix E*

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**The court has entered the following order:**

Case No. **96-3676**
Kimberly Schreiber v. Physicians Ins. Co. of WI
Trial Court Case No. 92 CV 298

The court having considered the Motion for Reconsideration filed in the above matter,

**IT IS ORDERED** that the Motion for Reconsideration is denied, with $50.00 costs.

Marilyn L. Graves
Clerk of Supreme Court